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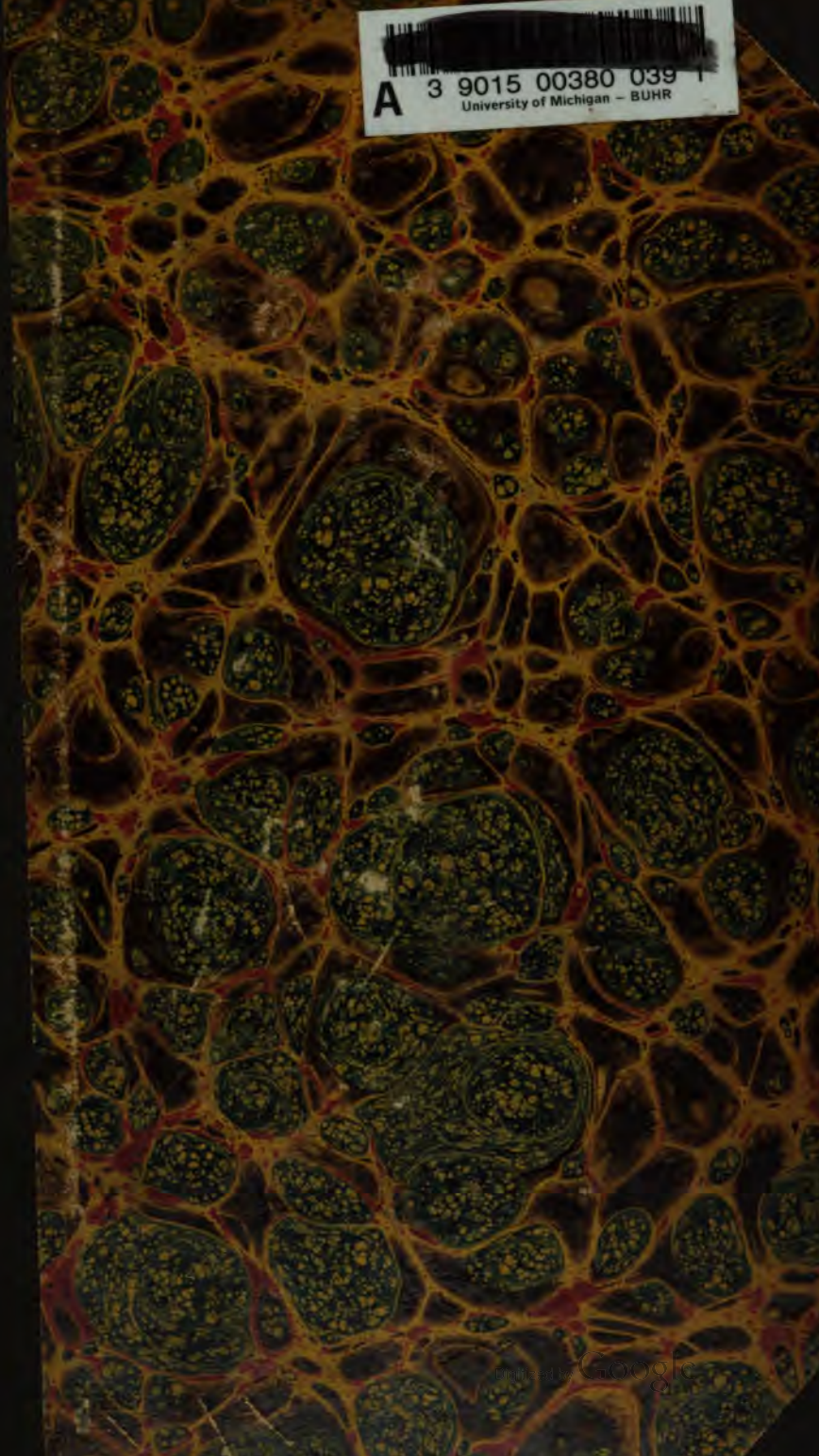
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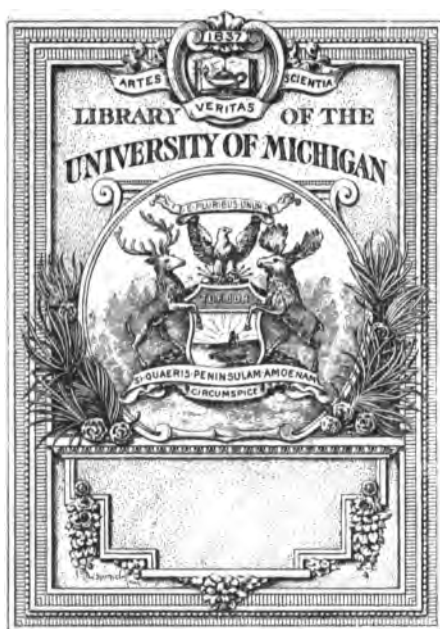
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CONTENTS:

	PAGE.
Abernethy, anecdote.....	378
Abortion, asafetida.....	462
flooding of.....	466
to induce.....	41
treatment of placenta.....	74
Abscess without scar.....	518
Acephalous Monsters.....	252
Acid drinks.....	229
Aconite, preparations.....	263
Adulteration, fable.....	334
After-pains.....	128
Agnew, <i>Per'neum</i>	275
Ague, alum in.....	258
Albuminuria, malarial.....	289
Albumin, test of.....	414
Alcohol in burns.....	33
on digestion.....	132
Allingham, <i>Rectum</i>	274
Amenorrhœa, manganese.....	405
Amer. Gyn. Soc., <i>Trans.</i>	182
Amer. Med. Ass.....	576
<i>Journal</i>	521
Amer. Pub. Health Ass'n,.....	238
Amer. Sur. Ass'n, Editorial.....	235
"A Model Institution.".....	144
Anal glands.....	160
itching.....	230, 232
Anatomical preparations.....	378
flexible.....	331
Anesthetics.....	145
in labor.....	2, 167
local.....	376, 377
Antiseptics.....	322
in maternity hospital.....	272
non, in ovariectomy.....	273
Aneurism.....	15
Aphasia.....	295
Apomorphia, as an emetic.....	555
Apparatus to secure position for pelvic operations.....	313
Arsenic, dialysed iron.....	83
Arteries, Surgery of.....	13
Ashhurst, <i>Surgery</i>	234
Athill, <i>Women</i>	184
"August Supplement.".....	139
Axillary glands in cancer.....	129
AYRES, S. C., Retinitis albuminurica.....	63
Bacteria, Sic transit.....	413
BALDWIN, J. F., to disguise quinine.....	255
Bartholow, <i>Electricity</i>	322
Batley's Operation.....	93

	PAGE.
BEACH, J. N., Physicians as students.....	108
Beale, <i>Slight Ailments</i>	323
BEMUS, W. M., Fistula.....	330
Bicycle.....	567
Bile.....	62
Bill, old.....	283
Bitter Salines, to take.....	288
Bladder, exploration through incision.....	69
small stones in.....	70
troubles in women.....	6
BLEILE, A. M., Digestion.....	58
Blistering by chloral.....	471
Blood vessels in war.....	265
Blymyer, A., Obituary.....	384
Bowel complaint in infants.....	82
Breast, cancer of, axillary glands.....	129
gathered.....	380
Bright's disease, symptoms.....	133
Bromide of Ethyl.....	479
Bromides, danger of combining.....	470
value of.....	470
Brown S. C., Obituary.....	142
Brubaker, <i>Physiology</i>	567
Buboes, carbolic acid.....	37
Bullet wounds, treatment of.....	35
Burdock in psoriasis.....	237
Burns.....	33, 314
"Cad of a Doctor.".....	427
Calcium Sulphide.....	165
Calomel in diphtheria.....	238
Cancer of Intestinal tract.....	441
Carbolic Acid, abuse of.....	433
buboes.....	37
causing gangrene.....	32
in piles.....	284
Caries of cervical vertebræ.....	227
Carpenter, <i>Practice</i>	567
Cathell, <i>Physician</i>	136, 320
Central Ohio Med. Soc.....	480
Cereal foods under the microscope.....	
Cerebral localization.....	11
Cerebro-spinal meningitis.....	85
Cerumen, borax.....	561
Chancre, excision of.....	313
of cervix.....	77
Charities, medical, abuse of.....	90
Children, pneumonia in.....	117
Chisholm's aphorisms.....	71
Chloral as a vesicant.....	471
large dose.....	82
varicocele.....	164

	PAGE.		PAGE.
Chloroform, death.....	534	Dispensatory, U. S.....	563
goblet inhaler.....	270	Doctor, first in Bible.....	192
water.....	264	new.....	93
Chrysophanic acid, to prevent staining.....	128	struggles.....	482
Cincinnati Sanitarium.....	479	view of Man.....	95
Circum-anal glands.....	160	Donaldson, <i>Gynecology</i>	234
Circumcision.....	458	Doses, frequent.....	511
Cirrhus of liver.....	538	Drainage in Dropsy.....	518
Club-foot, congenital.....	128	Draper, <i>Chemistry</i>	274
Codeia, or morphia.....	43	Dropsy, drainage.....	518
Coffinism.....	86	Drowning, signs of.....	143
Cold in the head.....	143	Druggists, re- sponsibility of.....	93, 253, 260, 285
Colic, quinine.....	372	Drunkennes, coma in.....	259
Col. Med. Col. Imbroglio, Aug. supplement.....	—	Drunk or dying.....	186
Coma, diabetic.....	507	DUMM, C. S., Aphasia.....	295
in inebriety.....	259	Gastritis.....	152
CONKLIN, S. A., Etiology of fevers.....	385	Duodenitis.....	152
CONKLIN, W. J., Fracture of neck of femur.....	193	Dysentery.....	371, 392
Osteoid Sarcoma.....	362	Dysmenorrhea, Mercury.....	128
Pneumonia in children.....	117	Dystocia due to hydrocephalus.....	533
Connor, <i>Eyesight</i>	318		
Constipation, cascara.....	467	Ear ache.....	512
rectal.....	269	Ear-wax, borax.....	561
Cornil, Syphilis.....	180	Eclampsia, puerperal.....	379
Contagious diseases, isolation after.....	372	Eczma, anal.....	230
CORNWELL, H. G., Cyst of frontal sinus.....	124	Winter.....	176
Coronary artery, Secondary hemorrhage.....	288	Edes. <i>Handbook, U. S. P.</i>	562
Corpus luteum.....	41	Editor—Wanted.....	47
CORLETT, W. T., Skin affections.....	502	Elephant, birth of.....	76
Cosmoline in cough.....	417	Embalming, new method.....	336
Crede's Method.....	3	Empyema.....	35
CROTHERS, T. D., Inebriety.....	400	Tapping.....	559
Croup and Diphtheria.....	436, 477	Engleman— <i>Labor</i>	185, 447
Cure of hip disease.....	200	Epilepsy.....	409, 471
Curette for chronic cystitis.....	107	Epistaxis.....	421
Cuyahoga Co. Med. Soc.....	523	Epithelioma, ergot cure.....	312
Cystitis.....	107, 160, 314	to produce.....	329
Cyst of frontal sinus.....	124	Esmarch, <i>Injuries</i>	568
		on blood-vessels in war.....	265
Dacryoliths :.....	72	Esophagostomy.....	517
Dalton, <i>Physiology</i>	181	Esophagus, permanent catheterism.....	163
DARR, H. H., Dysentery.....	392	Ether, injection of.....	177
Davy's artery compressor, death.....	68	Etiology of Fevers.....	385
Day, <i>Headaches</i>	564	Examining boards.....	192
Dayton Hospital.....	279	Extra uterine Pregnancy.....	78
Death, Muscular Auscultation.....	159		
Painless.....	308	Eyesight, to secure.....	318
Delirium Tremens.....	467	Falling of gravid Womb.....	78
Desquamation, doctrine of.....	305	Farquharson, <i>Mat. Med.</i>	423
Diabetes.....	507	Fat, diet.....	89, 307
puerperal.....	316	Fat Embolism.....	228
Diabetic Coma.....	507	Fee bill, Central Ohio.....	527
Diagnosis of Insanity.....	353, 393, 483	Fees, determination of.....	282
Dialysed Iron.....	415	Felix mas.....	178
in arsenic poisoning.....	83	Femur, fracture of neck.....	193
Diet for Fat.....	89, 307	Fevers, Etiology of.....	385
Digestion.....	58	Finger as pleximeter.....	329
Diphtheria, Calomel.....	238	Fire-proof garments.....	144
Diploma mill.....	329	Flint, <i>Diagnosis</i>	568
Dislocations, old, at Shoulder.....	132	Food for Infants.....	273
		Foreign bodies in air passages.....	36

	PAGE.
Fothergill, <i>Therapeutics</i>	276
Freckles.....	510
Frequent doses.....	511
Frontal Sinus, cyst of.....	124
Frost bite.....	230
Galactagogue.....	75
Galactorrhœa.....	273
Gangrene from Carbolic Acid.....	32
neurotomy.....	518
Gastric juice.....	59
Gastritis.....	152
Gastrostomy.....	247, 517
Genius, Money, Skill.....	192
Gonorrhœa.....	264, 422, 455, 561
is it Specific?.....	373
Goodwin, <i>Hosp. Treatment</i>	424
Gray, Hair, Sudden.....	335
GREEN, D. W., Panophthalmitis.....	249
Griesinger, <i>Mind</i>	136
Guiteau.....	45
Gundry, address.....	579
Hair, Suddenly gray.....	335
Hamilton—Circular.....	142, 140
Happy family.....	139
Hardaway, <i>Vaccination</i>	319
Hart, <i>Gynaecology</i>	473
Headache, salicylates.....	285
Hearing, to secure.....	318
Heart murmurs in puerperal state.....	39
Heckerman, W. H., death of.....	381, 383
HEDGES, W. B., Pneumonic fever.....	49
HELMICK, J., Croup and Diphtheria.....	439
Hematuria, pepsin.....	268
Hemorrhage, Nelaton.....	36
to check.....	229
Hemorrhoids, carbolic acid.....	284
Henock, <i>Children</i>	135
Hereditary Syphilis.....	113
Heredity in crime.....	556
Herman, <i>Pharmacology</i>	474
Hernia, cases.....	525
reduction of old.....	34
local etherization.....	312
points in.....	416
Herpes zoster.....	372
Hewitt, <i>Women</i>	321
Hicough for 26 weeks.....	304
Higgins, <i>Oph. practice</i>	277
Higher Education of Medical Men.....	206
Hip disease, muscular action.....	34
Hip-joint disease.....	200
Allis.....	268
Hot water heating.....	286
Humanitarian Invention Ass'n.....	579
HUMPHREYS, C. H., Hydrocephalus, Dys-	
toscia.....	533
Puerperal fever.....	500
Hyde, <i>Skin</i>	474
Hydrocele.....	456

	PAGE.
Hydrocephalus, a cause of Dystocia.....	533
Hysteria, atropa.....	317
Cauterization of Clitoris.....	462
Idiocy.....	353
IKIRT, G. P., Anesthetics.....	145
Illinois State Board of Health.....	46
Imbecility.....	353
Imbroglia, Col. Med. Col., Aug. Supple-	
ment.....	
Impacted fracture of neck of femur.....	193
Incontinence of urine.....	258, 270
Incubator, for Infants.....	272
Index Catalogue.....	325
Indiana Med. Jour'l.....	187
Inebriety, acid phosphate.....	262
Coma in.....	259
heredity of.....	556
its problems.....	400
Infancy, Narcotism in.....	125
Infants, to prevent bowel disease.....	82
Inflammation of Stomach.....	152
Innominate, ligated.....	281
Insane Women, Sexual Organs of.....	408
Insanity, Diagnosis.....	353, 393, 483
Intermittent fever, with Albuminuria.....	289
Intestigo.....	42
Intestinal juice.....	60
Intussusception.....	270, 459
Iodoform, Lister.....	162
poisoning by.....	378
to disguise.....	94
Ipecac as an oxytocic.....	127
Irrigation, stomach.....	472
Isolation after contagious diseases.....	372
Itching of jaundice.....	372
JACKMAN, F., Typhoid fever, by ergot....	300
JENKINS, M. J., Chloroform death.....	534
KELLY, W. J., carbolic acid.....	433
hereditary syphilis.....	113
Kidney disease, microscope in.....	529
Kidneys, floating.....	306
KING, Chas., Puerperal mania.....	345
King, <i>Obstetrics</i>	181
KNIGHT, A. L., Practice of medicine.....	337
Koch's bugs.....	48
fat crystals.....	284
Laceration of perineum.....	4
LANDIS, H. G., Report on obstetrics.....	1
Laparo-elytrotyomy.....	37
Leffman, <i>Chemistry</i>	183
<i>Food adulteration</i>	323
Left-side pain.....	416
Leonard, <i>Anatomy</i>	136
Dose-book.....	185
Leucorrhœa, infantile.....	513
Listerism.....	42
iodoform.....	162

	PAGE.
Liver, atony.....	472
Lobelia.....	86
Local anesthesia.....	376, 377
Longstreth, <i>Rheumatism</i>	563
LOVING, STARLING, Cirrhosis of liver.....	538
Intermittent fever, with albuminuria.....	289
Lung, resection of.....	333
Lupus, or epithelioma.....	455
Malarial albuminuria.....	289
Malaria, in skin diseases.....	280
quinine and potash.....	416
Malgaigne's hooks.....	189
Manganese in Amenorrhœa.....	405
Mania.....	393
MARKEL, I. F., Microscope in diagnosis.....	579
MARSHALL, J. R., Croup and diphtheria.....	438
Mass. State Med. Soc. and the Col. Med. Col.....	432
Mastitis.....	380
McLaughlin, A., obituary.....	430
Measles, contagion of.....	510
Medical Profession and Schools.....	241
Medical Chronicle.....	187
Medicinal eruptions.....	309
Meigs' food.....	273
Melancholia.....	483
Memphis sewers.....	519
Menigitis, or typhoid.....	79
Mercury in dysmenorrhœa.....	128
Microscope, foods.....	46
in diagnosis.....	529
Missed labor, from rupture of uterus.....	78
Montgomery, <i>Procidencia</i>	321
MORGAN, C. L., spina bifida.....	158
MORSE, D. A., Cerebral localization.....	11
Diagnosis of Insanity.....	353, 393, 483
Mosquitoes, against.....	144
Murder or suicide.....	95
Murrell, <i>Angina Pectoris</i>	324
<i>Poisoning</i>	183
Muscular auscultation in death.....	159
MUSSEY, W. H., Curette for cystitis.....	107
death of.....	94
Narcotism in infancy.....	125
Nasal polypi.....	73
Neck of femur, fracture of.....	193
N. E. O. Med. Soc.....	481
Nephrectomy.....	162
Nerve-stretching.....	335
Nervous affections of skin.....	502
Nettleship, <i>Eye</i>	568
Neurotomy for gangrene.....	518
New Code, ayes and noes.....	478
New doctors.....	93
Night sweats.....	259
Nihilism.....	42
Nipples, cracked.....	40

	PAGE.
Normal position of pelvic organs.....	239
Obstetrics, Report on.....	1
Odors, to remove.....	192
Ohio State Medical Society 21, 44, 302, 522, 575	
Oleates.....	356
Ophthalmia, calcium sulphide.....	162
Sympathetic.....	71
Ophthalmic aphorisms.....	71
Opium habit, to suppress.....	578
Otitis Media.....	457
Otorrhea.....	460
"Our Vindication," Dec. Supplement.....	241
Ovariectomies, Tait's.....	463, 465
Ovariectomy, nonantiseptic.....	273
in an infant.....	273
tapping.....	40
Ovarian cell.....	169
pathognomonic.....	42
trocæar.....	462
tumors, dystocia.....	379
Oxford Retreat.....	139
Palm oil in phthisis.....	259
Pancreatic juice.....	61
Panophthalmitis from cartridge-shell.....	249
Paralysis in children.....	33
Parrish, <i>Inebriety</i>	564
Parvules.....	262
Patella, fracture of.....	189
Pepsin, in hematuria.....	268
Perinephric abscess.....	516
Perineum, laceration of.....	4
Periosteal Osteoid Sarcoma.....	362
Pessaries, lubricant for.....	273
Pessary in rectum, etc.....	287
new.....	226
Petroleum Emulsion.....	286
in cough.....	417
<i>Pharmacopœia, U. S.</i>	277
Phillips, <i>Mat. Med.</i>	135
Phthisis, antiseptics.....	233
by inhalations.....	134
night sweats.....	259
not contagious.....	371
palm oil.....	259
prodromata.....	43
Phymosis, circumcision.....	458
Physical diagnosis.....	79
Physicians as students.....	108
and Bicycle.....	569
Placenta after abortion.....	74
previa and twins.....	430
Playfair, <i>Hysteria</i>	562
Pneumonia after opium poisoning.....	79
in children.....	117, 508
Pneumonic fever.....	49
Pooley, removal.....	479
Potter, <i>Anatomy</i>	276
Pott's disease, in neck.....	227
Practice of Medicine.....	337
PRATT, E. B., Croup and diphtheria.....	439

	PAGE.
Pregnancy, new sign of.....	271
teeth extraction.....	271
prolonged.....	272
Prescription dangers.....	260
Pressure to Uterus.....	215
Primipara, Ancient.....	41
Procidencia of gravid Uterus.....	78
Prolonged gestation.....	272
Pruritus ani.....	230, 232
Publication Committee's rules.....	44
Publishers' announcement.....	48
Puerperal eclampsia.....	379
fever.....	494, 500
mania.....	345
Put directions on the prescriptions.....	285
Quackery, samples of.....	431
Quain, <i>Dict. of Med.</i>	565
Quinine, to disguise.....	255
Ranney, <i>Anatomy</i>	135
Ray, J. D., Obituary.....	285
Recto-vesical fistula.....	330
REED, R. H., Legalized Swindling.....	578
REEVE, J. C., Tr. of puerperal fever.....	494
Report on Obstetrics.....	1
Responsibility in prescriptions.....	253, 260
Retinitis albuminurica.....	63
Rheumatism, salicylates.....	170
Rhode Is. Med Soc.....	90
Roberts, <i>Anatomy</i>	424
Rohe, <i>Anesthetics</i>	324
Saliva.....	58
Salter, <i>Asthma</i>	424
Sarcoma, osteoid.....	362
Satterthwaite, <i>Histology</i>	473
Scalp wounds, treatment.....	515
Scars, to avoid.....	518
Schmidt vs. bacillus.....	328
Sciatica.....	73
Seiler, <i>Throat</i> , etc.....	567
SHARP, H. J., Croup and diphtheria.....	436
Higher education.....	200
Shawl straps to check hemorrhage.....	229
Sheldon, Benj., Obituary.....	331
Shingles.....	372
Shock, ether.....	177
Shoemaker, <i>Oleates</i>	324
<i>Potas. Chlor.</i>	320
<i>Syphilis</i>	323
Shoulder joint, old dislocations.....	132
SIHLER, C., Med. Profession and Schools.....	241
Silk, surgical.....	188
Skin affections, nervous.....	502
diseases, classes of.....	192
Soap-paper.....	94

	PAGE.
Specialism, plea for.....	332
SPEECE, N. V., Vesical disorders in women.....	6
Spermatic truss.....	286
Spina-bifida.....	158
Sponge grafting.....	214, 577
Spontaneous evolution.....	238
Spring diet.....	471
Sternum, removal of.....	269
Stewart, <i>Dose-Book</i>	425
St. Jacob's Oil.....	288
Stomach, absorption by.....	287
foreign bodies in.....	317
irrigation.....	472
Louisville resection.....	334
Styptics in surgery.....	458
Suicide or murder.....	95
Sulphur and malaria.....	285
Surgery of the arteries.....	13
Sympathetic ophthalmia.....	71
Syphilis at 80.....	95
hereditary.....	113
treatment at Vienna.....	551
Syr. ipecac. comp.....	478
Taliaferro, tampon.....	215
Tansy, deaths from.....	317
Tapeworm.....	178, 468
Tapping before ovariectomy.....	40
Teeth, extraction of in pregnancy.....	271
Temperature, low.....	578
Thermometers, verification of.....	92
Thompson, exploration of bladder.....	69
<i>Urinary Organs</i>	180
Tidy, <i>Legal Medicine</i>	425
Tilt, <i>Change of Life</i>	274
Tobacco and its effects.....	369
by boys.....	257
Toledo Medical College.....	382
Schools.....	475
Tonic Chlorides.....	469
Tonsils, enlarged.....	420
Tonsillitis, guaiac.....	258
Toothache.....	422
Toy pistol, Editorial.....	91
Trachea, nut in 18 days.....	422
Treatment, skilled, how determined.....	282
Trichina, to detect.....	84
Tracheotomy in young subjects.....	311
Troeltsch, <i>Ear</i>	236
Tyndall, <i>Light</i>	325
Typhoid fever, abscess and polyuria in.....	372
ergot.....	300
a personal attack.....	97
or tubercular meningitis.....	79
treatment, Editorial.....	137
Ulcers.....	160
Umbilical cord, strength of.....	408
Urethra, abscess of.....	456

	PAGE.		PAGE.
Urinary abscess.....	456	Vulvae pruritus.....	232
Urine, incontinence.....	258, 270	Walsh, <i>Call-Book</i>	277
to examine.....	307	Wanted--an Editor.....	47
U. S. Dispensary.....	329	Water, drinking.....	509
Uterus, normal relations of.....	239	Weist, foreign bodies in air passages.....	36
falling of gravid.....	78	WHITE, P. M., muscular auscultation.....	159
procentia.....	321	Sponge-grafting.....	214, 577
rupture of, etc.....	78	Whitman, <i>Leaves of Grass</i>	179
shortening round ligaments.....	379	Whooping Cough.....	264
Vaginal douche.....	315	petroleum and cosmoline.....	417
Van Buren, Obituary.....	481	WOODRUFF, L., Acephalous monsters.....	252
Vance, R. A., Cancer of intestinal tract.....	441	Wood's Library.....	425
Radical cure of hip-joint diseases.....	200	Wrapper, anti-quack.....	418
Surgery of the arteries.....	13	Wrist, painful affection of.....	69
Varicocele, chloral.....	164	W. Va. State Med. Soc.	30, 576
Vesical disorders of women.....	6	Board of Health.....	328
Vesico vaginal septum, to fix.....	513	Yellow fever, diagnosis.....	88
Viburnum prunifolium.....	273		
Vick, <i>Guide</i>	325		
"Vindication, our," Supplement.....	241		

and prolonged labor? To smother the evidence of abnormal conditions; or to relieve or remove the latter by appropriate treatment? There can be but one answer, and the only rational advocacy of anesthetics in labor must be based upon their power to harmlessly relieve abnormal conditions, and not as a mere palliative of pain. That anesthetics have such power in some cases, I freely grant, but believing, also, that other means are more efficacious, I enter a protest against their indiscriminate use, or their use in any other capacity than as a therapeutic agency in eclampsia, version, or the like. To regard labor as a long scene of agonizing suffering, which needs to be treated as a capital operation in surgery, is certainly to advance backwards; to ignore the many means at our command for shortening and alleviating the process; and, in many cases, is simply to pander to the hyperesthetic and homeopathized prejudices of fashionable women in defiance of the better knowledge of the physician himself.

The further discussion and dissemination of methods long since propounded but too little noticed, finds its most important example in the papers which have appeared during the year upon the *Method of Delivering the Placenta*, known as the method of Crede—among which is one from Crede himself, others from Weiss, Dohrn and Fehling. These for the most part contain further evidence as to the great value of the method, and also point out some of the reasons why it has not attained to universal countenance. Prominent among these is the fact that Crede, by his own admission, did not adequately state the method of procedure in his first paper. Indeed, he was but little more explicit than Blundell, whose statement is as follows: "When the placenta is retained in the uterus, independent of any very active manual operation, we may sometimes obtain its expulsion by merely laying the hand on the womb externally, feeling it through the abdominal coverings, grasping it and thus stimulating its fibres to contract, the placenta being expelled, or, to use a coarse but significant expression, this viscus being squeezed forth by the action of the hand." (Lectures 6, p. 318). Certainly a great misapprehension of the method exists in this country. I frequently come in contact with two classes of physicians, those who claim to use the method and those who claim to have used it and abandoned it; but on close investigation I find that they never do, or did, really employ it, but only some vague manipulation which they suppose to be it. One great mistake is in thinking that the uterus is at once to be grasped after delivery, and the placenta expressed. Into this error I fell myself, and came very near dismissing the practice as chimerical.

II.—I.—I.

As far as it can be stated in words, I should say that after the child is delivered and separated, a hand should be laid upon the abdomen and the womb stroked, rubbed, or kneaded, until a firm contraction is established. When this occurs, the womb usually is elevated and pushed forwards, and one or both hands may now grasp it through the abdominal wall, almost as well as if it were out of the body. The womb is then squeezed, not promiscuously, but with the intelligent design of grinding off and pushing out the flat, cake-like mass of the placenta. This may be felt to take place, and then a downward pressure is combined until the placenta is shot out of the vulva, sometimes with considerable force. Occasionally, owing to the imperfect contraction of the womb, the placenta is slow in being separated, and we must then intermit our efforts and try again after a few minutes. Occasionally, also, the placenta has been inverted during delivery of the child, owing to natural or relative shortening of the funis, and then the method will rarely succeed in expelling the placenta entirely, while even then it will render it more accessible to the fingers per vaginam.

A certain amount of tact and art is required to supplement any rules of procedure. The advantages of this method are conspicuous. The placenta is expelled sooner, to the satisfaction of both patient and physician. According to the statistics of Fehling, the duration of the third stage is as 7.7 minutes to 13.4 minutes, when left to nature. The loss of blood is less, according to Weiss, by about one-half. The uterus is thoroughly contracted, and post partum hemorrhage is unknown to the disciples of Crede. The uterine sinuses are thoroughly emptied, and thus a great cause of puerperal disease is removed, and child-bed mortality directly lessened. The practice obviates the necessity of introducing the hand into the uterus, and greatly diminishes the number of cases of adherent placenta, hour-glass contraction, etc. In fact, according to Chantrenil, these things are never witnessed when the practice is faithfully carried out. Advantages so great would surely be looked upon less apathetically by the American profession if this method was thoroughly understood, and the papers mentioned may therefore be regarded as most valuable agents of progress if they succeed in aiding the universal adoption of the method of Crede.

The subject of *Laceration of the Perineum* during labor is one which has received of late much attention, and bids fair to be placed in a brighter light than in the past. In the spring of last year I published a paper setting forth the desirability of deliv-

ering the head in the absence of uterine contraction, either with the forceps or by the Smellie-Ould method of extracting the head. With additional experience I am still more confident that when the head can be so extracted, the womb and woman being entirely passive, the perineum will surely be preserved, except in cases where there is an inherent defect in the structure. But I as freely admit that we cannot always secure the conditions of success, and therefore I welcome any further methods which promise success. Of these the only noteworthy one is that of Prof. Reamy. It consists in applying a single fold of towel against the perineum, the ends being gathered up in the hands of the physician, which are placed opposite each hip of the woman. In this way an additional layer of quasi-perineal structure is provided, and we have the word of the inventor that he has never failed to save a perineum by its use. Theoretically the perineal body, which sometimes is ruptured while the skin is uninjured, is just as liable to accident as when this method is not used, and therefore large experience is necessary before deciding fully as to its merits. Important as this subject is, it is ludicrous to see how it (and many other subjects) is sometimes exaggerated. A few years ago the casual reader of obstetric literature might fairly have thought that at last, but in a more proper sense, the words of Mephistopheles to the student had become true:

“Es ist ihr ewig weh und ach
So tausendfach
Aus einem Punkte zu curiren,”

and that the origin of all female woes could be traced to the laceration of the perineum; their cure to the surgical repair of that structure. Scarcely was this ghost laid than another was conjured up, and a lacerated cervix was found to be the real culprit. In the last year some effectual exorcism has been directed to this phantom, not only by professed disbelievers, like the venerable Bennet, but by able advocates, such as C. C. Lee, and even its great originator, Dr. Emmet. There can be no question as to the great value of the operation when expertly performed in suitable cases, but it is a great relief to know from prime authority that one need no longer blush for shame because he is not in the daily habit of sewing up several lacerations before breakfast.

It is unfortunate that the practice of gynecology has been invaded to so great an extent by surgery. There is no reason why important cutting operations, such as ovariectomy and the removal of the uterus, should be taken from the surgeon. On the contrary, much harm has been done by building up a class of very specialized surgeons, the brilliancy of whose

work has dazzled the younger members of the profession to such an extent that the more humble work of topical and general medication for uterine disease is sadly neglected. In my opinion there is little need for a special department of gynecology. It is true that from advantages of temperament and training some men will be more successful than others in the tedious treatment of uterine disease. But it should not altogether be divorced from general practice. The general practitioner who is not well informed in this department, cannot practice justly for a single day, since diseases of almost any kind occurring in women are very generally associated with pelvic derangements, either by way of cause or effect. And the pure specialist, ignorant of the latter class of conditions, is equally deficient. If surgery were left to the surgeon, I am confident that the spread of real knowledge as to the treatment of pelvic disorders would be more rapid and universal, and that the profession in general would be the gainer.

VESICAL DISORDERS OF WOMEN.

BY N. V. SPEECE, M. D., QUINCY, O.

A paper read before the Logan County Medical Society.

Among all the ills that affect suffering humanity, there are, perhaps, none which give so much annoyance to the medical attendant, or suffering to the patient, as those affecting the urinary organs. Especially is this true of the gentler sex. Women are seemingly more susceptible to urinary derangements than males. Any one who will make a study of the anatomical relations of the organs of the female pelvis, will be able to fully account for this.

It is my aim in this paper, to investigate some of the most troublesome of these urinary disorders of women, as to their causes, treatment and prevention.

Every country practitioner knows that he is often consulted by women with complaints that there is something wrong with their urinary organs. The patient will say that her bladder is certainly inflamed, as she has frequent calls to void her urine, that at such times she suffers a good deal of pain, that after making the attempt to empty the bladder, there is great bearing down pain, that there is but little urine voided, that there is a burning sensation, probably a little blood being passed also, and that after all her persistent efforts to empty the viscus, she still gets no

relief, but that her sufferings are rather increased. He will remember, too, that with all this history of the patient before him, he has contented himself with asking a few formal questions, and a prescription for a little sweet spirit of niter, together with a word of consolation to go home, take the medicine and keep quiet, and that she will soon be well. He dismisses the patient, with her ailment, from his mind and thinks no more of the matter.

Fatal mistake, often, that!

The poor woman, with all confidence in her medical advisor, goes home with his words comforting her heart, and takes her medicine only to find that she fails to grow better. Indeed, in three-fifths of all these cases the patient rapidly becomes worse, and, in many instances, the disease goes on until life becomes a burden too intolerable to be borne, and which she would gladly lay down, were it possible to do so, to escape her continued and horrible suffering. She becomes an easy victim of the opium habit, and goes down to the grave a miserable mortal.

This is no fancy picture, drawn for the sake of effect and a display of rhetoric. Scores of such cases exist in every community throughout the country; and they exist frequently without coming to the knowledge of the physician, simply from the fact that we often fail in our examinations of patients to properly question them, and the innate modesty of woman deters her often from telling the physician all the particulars of her case. Much suffering and trouble might be saved the patient, and often a deal of mortification to himself, if the physician would only take the time to carefully look after this class of patients, and not dismiss them with a passing thought and careless examination.

Few women escape these vesical disorders. At some time during her life, nearly every woman is sure to have trouble in this direction, and when a woman comes suffering in this way, we should learn the history fully, and thus lay the foundation for a rational and intelligent treatment.

The causes of cystic diseases of women are either intrinsic, or extrinsic; that is, they will be found to exist in the bladder or external to it. To the former belong those afflictions which arise from reflex action; in other words the trouble is sympathetic or functional. The latter are the result of structural changes, or organic lesions. When a patient tells us she has painful micturition, it is proper for us to find out, if possible, whether it is due to causes that exist within the bladder or external to it. She may have had, a short time before, a long and difficult labor and the long continued pressure of the head of the child upon the viscus may have so

bruised or destroyed vitality as to excite sloughing, or have lighted up an inflammation that has thickened the delicate mucous membrane, and produced such rapid structural changes as will be exceedingly difficult to overcome. She may have, in this case, or from this cause, no relief by lying in bed, but if it come from displacements of the uterus, or from pelvic tumors, she will experience marked relief by lying in bed. It may come about from urinary calculi, or she may have gonorrhea, or the urine may be of an irritating character, or she may "have had a chill," or she may be hysterical and thus mislead you, or, last of all, she may be pregnant. It is remarkable what an amount of disturbance the gravid uterus will stir up in this direction. Fissures in the rectum, and hemorrhoids, are fruitful sources of vesical irritation. Of course, one feels a natural delicacy in questioning a lady on these subjects; one naturally feels loth to suggest to a modest and retiring woman the propriety of making a vaginal or rectal examination; and she feels that you ought, by some "hook or crook," to diagnose the difficulty without subjecting her to this trial. I desire to say, however, that there is no alternative; if we desire to know conclusively all it is possible to know about the diseased conditions we must make careful and thorough investigation. There is no use dallying on the part of the physician; he must proceed to make an honest, thorough and critical examination, and he will stand a reasonable chance of success in fixing the difficulty where it belongs; and then good judgment and the resources of our science will furnish the means for relief and cure. It is not so difficult as it would at first thought seem to be, to get the consent of the patient to an effort to diagnose her disease. Properly explain to a patient why the examination is necessary, and if she is a reasonable woman she will submit; but if she will not, it is far better for us to resign the case, and let her seek elsewhere for that relief she refuses us the opportunity of offering. Having gained her consent to the examination, patiently and thoroughly explore the bladder, rectum and vagina, carefully manipulating all the surrounding parts. No hasty or superficial examination will answer. No guess work ought to enter into the case at all. Be sure you are *right* then stop, and not until you are satisfied fully of this fact are you authorized to desist.

Having found out what the matter is, the next question is, what shall we do to cure, or at least to relieve the patient; for it is a lamentable fact that many of these cases have gone on until they are not susceptible of cure, but only of temporary relief. In treating of this part of the subject, I shall first speak of the disorders which arise from external causes, re-

serving what I may have to say of organic causes to the last. If we find displacement of the uterus, this must be reduced, and the uterus kept in place by the introduction of a good pessary. "It is an evident fact that if anteversion exists, and the womb is enlarged and sags in the pelvis, the upper portion of the vagina is relaxed and when the uterus reaches a certain point of prolapse the whole weight is suspended from the neck of the bladder."* When this condition exists, there is excited a constant desire to empty the bladder; but no relief is secured; and every succeeding effort only gives rise to more severe tenesmus. Repositing the anteverted uterus, and promoting measures to successfully keep it repositied, is the proper treatment. Under these circumstances, too, the injection of warm water is a grand remedy, and one which seldom fails to do good. Place the patient on her back, and either by the siphon method, or a Davidson syringe—using a double catheter in both instances—inject large quantities of warm water. Often the pain is increased at the time; but after the evacuation of the water, make an injection of a solution of morphia, and the absorbent power of the mucous coat of the bladder, though not very great, will answer the purpose admirably.

Among the most prolific sources of vesical irritation is over-distension. A woman will ride for miles, on a damp, chilly day, and because no seemingly favorable opportunity offers does not empty her bladder, and the over-distension becomes so great that weeks and months of horrible suffering ensues, and the foundation is laid for a miserable remnant of life. I know of nothing that relieves so quickly and permanently cystic irritation from this cause, as the use of the catheter and the rapid dilatation of the urethra. Some of the highest authorities, however, differ upon the question of dilatation, as to its usefulness. Emmet claims that the harm likely to be done is greater than the relief to be obtained. He says that incontinence is sure to be the result, and that far more permanent results are to be obtained by other means, and thus the risk of producing incontinence by over-stretching be avoided. On the other hand, Goodell says it is the treatment that is most available, and that with ordinary care no danger need be apprehended in the direction claimed by Emmet. In my own experience, I have dilated the urethra in a number of instances, with no ill results, while the patient experienced immediate relief. Where great tenderness of the walls of the bladder is found, the following mixture will be found to exert a beneficial influence: R. Tr. iodinii; fl.

*Emmet's *Gynecology*, p. 740.

ext. belladon., *aa* ʒss. M. Paint this mixture on and over the points of tenderness, two or three times a day.

Atropia appears to exercise a wonderful influence over all forms of vesical irritation, and I have found the prescription of Prof. Goodell, of Philadelphia, to answer the purpose admirably :

R. Atropiæ.....gr. j;
 Acidi acetici.....gtt. xx;
 Aquæ, alcoholis.....*aa*, ʒ iv. M.

S.—Four drops in a wine glass of water, three times a day; to be increased or diminished as the exigencies of the case demand.

If much irritation exists along the track of the urethra, to relieve the terrible tenesmus a suppository of cotton wool, soaked in a solution of chloral in glycerine and push up along the anterior wall of the vagina and under the arch of the pubes, will remove the pain and secure rest. Warm hip baths, injections of warm water into the vagina, or suppositories of belladonna, or hyoscyamus, have a soothing influence. Sometimes fl. ext. of buchu, to which a few drops of ext. of belladonna have been added, given in doses of 40 to 60 drops, once in six hours, proves of value.

Where fissures of the rectum or hemorrhoids are found, active measures are to be instituted by cauterizing the fissure with a solution of nitrate of silver, forty grains to the ounce of water; or painting with a mixture of chloroform and glycerine. A few applications of this character will soon effect a cure of the fissure. An operation for the removal of the hemorrhoidal tumors, either by snipping them off with a sharp pair of scissors, or by ligation will be the proper thing to do. If ulceration of the os uteri, laceration of the cervix, or any other trouble is found, which is producing reflex action, vesical irritation, you will adopt such measures for relief as experience has taught to be most effectual.

Careful attention to the general health is demanded. Iron, quinine and a good generous diet, together with perfect cleanliness, and quiet of body and mind, are essentials not to be neglected. If these indications for treatment are followed, and the patient obeys orders, a reasonable degree of success is assured.

In the second place, I come to notice those causes intrinsic in their character, and the treatment necessary under these circumstances. If, upon introducing a sound, a stone is found, it can be removed either by crushing or by making an opening through the vesico-vaginal septum and extracting it. If a cystitis has been neglected for a length of time, until extensive ulceration and thickening of the coats of the bladder have taken

place, nothing but surgical interference seems to be of any avail. Relief is obtained and a cure effected by creating an artificial vesico-vaginal fistula. This should not be undertaken, however, before the urine has been properly and scientifically tested. An analysis of the urine often shows grave disorganization or disease of the kidneys, and, if so, the operation would likely prove a failure, as death would probably ensue from uremic poisoning. It is claimed by Emmet, in his book on Gynecology, (to whom, together with Dr. Goodell, of Philadelphia, I am indebted for many thoughts of this paper), that the anesthetic employed is not properly eliminated from the blood on account of the failure of the kidneys to act, and that uremic poisoning of the blood is a sure result.

For a description of the method of operating for artificial vesico-vaginal fistula you are referred to Prof. Emmet's book, which, by the way, every physician who wants to keep up in the current medical literature of the age ought to own and read.

Having spoken of the nature and causes of vesical disorders and their treatment, it only remains for me to say something regarding their prevention. If it were possible to influence women to forego many of the fashionable follies and extravagancies of the age, it would be one means of stamping these ills to death. So long, however, as fashion has her devotees, she will have enough of victims. Thin shoes, insufficient clothing, going into the open air laden with moisture, often with no covering for the head, long rides after night, when not properly protected, criminal neglect in allowing over-distension to occur, together with sexual excesses, will ruin the urinary organs of any woman.

Another thing that ought to be banished from every home in the land, is that woman killer, the sewing machine. The machine, with the corset, ought to be relegated to destruction, never to be resurrected again. However little a woman may use a sewing machine, it will produce just that much urinary and uterine trouble.

CEREBRAL LOCALIZATION: TEMPORO-SPHENOIDAL LOBE.

BY D. A. MORSE, M. D., LONDON, O.

At a recent meeting of the Central Ohio Medical Association a case of cerebral hemorrhage, of rare form, was reported by Dr. Woodruff, of Alton, O., in which a clot "half the size of a hen's egg," and "four or five ounces of liquid blood," were found poured out into the temporo-

sphenoidal portion of the brain, external to the central gray masses, and internal to the cortical substance.

This case some weeks before death manifested convulsions, without loss of consciousness, no motor nor sensory disturbance following. There was intense pain at vertex of cranium. Dr. Wirth, who saw the case with Dr. Woodruff, diagnosed an hematoma. As the case has been published* I will not enter further into its details. It was obscure in its character, and being of exceedingly rare form, no better diagnosis would have been made by any one.

The functions of this portion of the brain have not been as well established as of other parts, but have in all probability been, to a considerable degree, declared. It probably has no very intimate relation with thought, sensation, or motion, unless the centers of tactile sensibility and special sense, in part, are located here. Experiment and pathological study attest this.

Writers upon the functions of the brain are not very elaborate in the consideration of this region. There are reasons for this. Motion and sensation in general, and the intellectual centres, having been determined, less attention has been given to a part so inaccessible as a part, at least, of the sphenoidal region. Disease also being more rarely observed, pathology is less directed towards this region. In Ferrier, *Functions of the Brain*, and also *Localization of Cerebral Disease*, Pitres; *Recherches sur les Lésions du Centre Ovale des Hemispheres Cerebraux*, and Goltz, Plüger's *Archiv für Physiologie*, we find more than elsewhere upon this subject. The substance of the information given us is "that electrical irritation of the superior temporo-sphenoidal convolution causes twitching of the opposite ear and other reflex indications of excitation of subjective auditory sensation." (Ferrier.)

Irritation lower down produces movements of the nostril, indicative of excitation of subjective olfactory sensation. Destruction causes no paralysis of motion, but is followed by loss of smell on the same side, and, when the neighboring regions on the same side are invaded, loss of taste on the opposite side of the tongue follows. (*Ibid.*)

Still further towards the base of the brain (hippocampal region), injury results in loss of tactile sensibility, such as follows division of sensory nerves.

These observations are based upon experiments upon animals. With

man lesions of this region have been observed in which no such disorder of sensation resulted. These cases are said to have latent lesions. Cases of abscess have been reported by Charcot and Pitres, Thibault, Humbert, and others, in which nothing was observed save the ordinary symptoms of an abscess.

Epilepsy furnishes us a large number of cases in which there is sclerosis of the hippocampal region. In these cases we observe disturbance of tactile sensibility. But as in cases of chronic epilepsy organic changes at the base of the brain are common, and not limited to this region, we can not attribute to this region the disturbances that result further than as they may tend to throw additional light upon the subject. To be conclusive, the lesions must be more limited and exclusive, unless limited and exclusive lesion confirms the theories. When the function of a part is so clearly established that we can isolate and declare the symptoms that belong exclusively to that part, complication with lesion of neighboring parts will not so readily obscure diagnosis.

With regard to the part of the brain in question, it may be regarded as settled that when the lower portion of the temporo-sphenoidal lobe is destroyed, the sense of smell and taste will be abolished. It is to be regretted that cases reported contain so little information upon this point, the observer clearly having failed to give attention to these points. With the number of cases of abscess, the result of disease of the ear, we would expect to have more perfect reports, but the result shows that sensation and motion in general are alone observed, or deviation of the eyes when deeper parts are involved. No effort has been made in many cases to obtain information concerning the special senses.

SURGERY OF THE ARTERIES.

BY REUBEN A. VANCE, M. D., CLEVELAND, O.

Professor of Operative Surgery and Clinical Surgery, in the Medical Department of Wooster University; Consulting Surgeon to Charity Hospital, etc.

Read before the Ohio State Medical Society.

There can be little difference of opinion as to the broad distinction that theoretically separates the pathological results of arterial disease and wounds of arteries. In the one, a tumor due to arterial expansion results; in the other, a swelling caused by extravasation of blood is to be seen. In the former a sac, produced by the distended vascular tunics and compressed adjacent tissues, restrains the circulating fluid and keeps it within bounds; in the latter no sac is to be found, and the extravasated blood separates contiguous organs, dissects out important structures, and is only

checked when neighboring parts are compressed by unyielding fascial envelopes. In the one case we have an enlarged blood vessel; in the other, a wounded or ruptured artery. The treatment that should be adopted in these different cases has been obscured by the name given them. By calling such widely unlike morbid anatomical states as an enlarged vascular trunk, due to arterial disease, and an extravasation of blood, caused by a ruptured or wounded artery, by the same term, "aneurism," an unnecessary and very distressing complication has arisen. Students are compelled to associate the therapeutical procedures necessary for the cure of an aneurism with the cause of the individual tumor, instead of connecting the pathological lesion present in a given case with the restorative provisions of Nature. Observation teaches that Nature resorts to one or more of a restricted series of phenomena in her efforts to cure a tumor resulting from a distended artery; the deposition of layer after layer of fibrin in the aneurismal sac may obliterate the tumor; these layers may be so placed that the cavity is filled without obstructing the canal of the blood-vessel; a part of one of these layers may be so displaced as to close the outlet of the sac, the blood within the latter at once coagulating; or, finally, inflammation and suppuration may completely destroy the tumor. The first three of these four processes may cure; the last one is almost certain to kill. The great treasures of surgery have been unearthed by careful study and diligent imitation of Nature's processes. Thus, it has been discovered that these beneficial procedures of Nature differ in merit in the part of the body in which the aneurism is located, and can be accelerated or retarded by certain steps on the part of the surgeon. To aid in effecting a cure it is not necessary that the blood be stopped passing through the sac, although it is essential that the force of the circulation be diminished and the rapidity of its flow through the tumor reduced.

It is unnecessary for me to review the different measures surgeons have resorted to for the purpose of reducing the rapidity and force of the circulation; rest, position, pressure, compression, electro-puncture, the "old operation," manipulation and ligation, or torsion, are among the more important. In all these, in order that a cure be effected, it is necessary that a sac be in existence in which the blood may coagulate, or upon the walls of which layers of fibrin may be deposited, and that in those instances in which the main artery is occluded, that a collateral circulation be established. Many cases can now be cured by the milder agencies, reserving for those that resist the more radical procedures—ligation, torsion, or the "old operation." Surgical history has no brighter page than

that which records the contributions of Anel, Hunter, Brasdor, Wardrop and Syme to the surgery of arteries. Anel ligated on the cardiac side of the tumor, near the sac; Hunter tied higher up, where the artery was healthy; Brasdor went to the distal side of the tumor, ligating near the aneurism; Wardrop tied on the same side as Brasdor, but placed his ligature nearer the periphery. Of these procedures Anel's has no advantage not shared by Hunter's, while Hunter's possesses merits to which Anel's is a stranger. On the other hand, the Hunterian operation is free from dangers that beset the method of Anel. The distal operations—although both operations of necessity—differ as decidedly as the foregoing. The operation of Wardrop, however, has a bright outlook, and the surgical authorities of the day are among its earnest advocates. To Syme we are indebted for a revival of the "old operation"—a procedure imitating the fourth and last method Nature occasionally adopts for the cure of aneurism. Inflammation and suppuration may destroy an aneurismal tumor—unfortunately at the same time killing the patient by hemorrhage. Syme opened boldly certain aneurisms, turned out the clots, and tied the artery just at, but above and below the tumor. His success emboldened him to urge this method as one free from the great mortality of the Hunterian operation, and therefore especially valuable in iliac, axillary, gluteal and femoral aneurisms.

Before glancing at the state of a ruptured or wounded artery, and reviewing the phenomena that assimilate it to or distinguish it from an aneurism, it may be of interest to look at the changes which ensue when a ligature is placed upon one of the great arterial trunks. Essentially the same phenomena noted after severing the sympathetic nerve in the neck are to be seen; the dilatation of minute vessels and the speedy development of a collateral circulation are the features of greatest interest to the practical surgeon. Whether this result is brought about by destroying the vasomotor nerve supply, or not, is a minor question; it is a fact of observation that for some reason or other these vessels do open when the main trunk is ligated, and that in this way the all-important collateral circulation is established.

The principal surgical measure for the cure of aneurism is ligation or torsion. The great danger overshadowing all cases of ligation is secondary hemorrhage. Experience shows that the ligature itself contributes materially to this unfortunate result. Although the greater part of the wound may unite by first intention, still the ligature, that during the operation was soaked in blood, and for the forty-eight hours following,

was impregnated with wound secretions, ultimately occupies a funnel-like opening through which pus is drained—an opening communicating with the air at one end and reaching to the compressed artery at the other. The result is that decomposition commences at the surface, passes down the ligature, and finally surrounds the ligated vessel with a ring of putrescent material. Again, the ligature, where it compresses the artery—especially if the middle and internal coats are severed and retracted—destroys a certain portion of the external coat and necessitates a process of ulceration that in the end casts off this slough. There is, furthermore, in connection with these phenomena an interruption of nutrition not limited to the part directly grasped by the loop of the ligature, which exerts a material influence upon the reparative processes which seal the central and distal extremities of the artery. It is a fact of far-reaching significance, that the reparative process, which seals the distal end of a ligated artery, is much less perfect than that which closes the cardiac extremity. Whether this be due to disturbance of the nerve supply of the part, or that the blood in contact with the distal end has passed through the avenues making up the collateral circulation, and no longer possesses the peculiar tint and character of arterial blood, I am unable to say. Be the explanation what it may, the fact that the distal end of a ligated artery is less perfectly sealed than the cardiac extremity cannot be denied. Where this fact is borne in mind, it will surprise no one to learn that secondary hemorrhage far more frequently comes from the distal end of a ligated artery than from its cardiac extremity, although all our preconceptions—such as arise from our knowledge of nearness to the circulatory center, the force of the heart and the degree of arterial pressure—prepare us for just the opposite statement.

A knife is forced into the body and an artery wounded; the arterial injury is slight, yet the secondary changes, congestion, infiltration and softening of the walls of the vessel, ultimately cause the latter to yield. A more decided injury is inflicted; arterial blood flows for a time, hemorrhage ceases and the wound in the skin heals. In both these cases a pulsating tumor may soon form, revealing the fact that a so-called “false aneurism” has developed at the point where the artery was wounded. Contusions may injure or strains rupture an artery. In fractures a spicula may puncture, in necrosis a fragment erode an important vessel. In gunshot injuries an artery may be wounded, or in attempts at reducing dislocations a vessel may be torn. A “false aneurism” may follow any one of these lesions. Should it not invariably be denominated what it is—a

wounded or ruptured artery, and no longer called what it is not—an aneurism? The last reason I shall adduce in favor of this change of name, or rather, this return to the proper name, is that the treatment indicated in the one is contra-indicated in the other; the measures that cure aneurism are not those that should be adopted for the cure of wounds or ruptures of arteries.

Eliminating rest, position, pressure, compression, electro-puncture and manipulation, as agencies applicable to but few of the cases of true aneurism, we find that torsion or ligation, in some form or other, is the great remedy. As before stated, the Hunterian operation is the surgeon's choice; the distal operation may be a matter of necessity. The presence of a sac, in which the blood may be made to coagulate, or upon the walls of which layer after layer of fibrin can be deposited, is fully as essential to the cure of the patient as the temporary cessation of the circulation, or the ultimate establishment of a collateral blood-supply. How is it with a wounded or ruptured artery? Here the skin may be perforated and the artery punctured—hemorrhage at once ensuing. The steps to be taken by the surgeon are materially modified by the presence or absence of hemorrhage—the same lesion may require very different treatment before and after the flow of blood is checked. Again, a piece of necrosed bone may puncture an artery and cause extravasation of blood without a wound of the integument. The same condition occasionally results from strains rupturing arterial trunks, or fractured bones puncturing them.

If a wounded artery bleeds and can be easily ligated, it should invariably be tied or twisted. Slight hemorrhage from a deep artery should be treated by graduated compression over the wound—severe hemorrhage resisting pressure, by torsion or ligation above and below the bleeding point. So far there can be no doubt as to the rule that should guide the surgeon; but what course shall he pursue when blood has been extravasated and is constantly accumulating in the tissues? Or, what do when the tissues are filled with clots, although apparently no more blood is flowing?

There can be no difference of opinion as to the principle that should guide the operator in many of these cases. He may be forced to forego ligating both ends of a bleeding artery when the finding of these structures necessitates great violence to important organs. Thus, after rest, position, pressure, etc., fail to check hemorrhage from a wound in the hand or foot, the brachial or femoral artery is tied or twisted, and gradu-

ated pressure applied. We now find the altered circumstances under which the latter operates sufficient to effect a cure. It is, however, in those cases where

First, a pulsating tumor forms about a ruptured vessel, or after the wound that injures the artery has healed upon the surface; *Second*, where blood has accumulated and still accumulates in the tissues about a wounded artery, external hemorrhage having ceased; *Third*, where an enormous amount of blood distends to the utmost the parts about a ruptured or punctured artery—that authorities are not in unison as to the best course to be pursued, and where a rule should be formulated for the guidance of the operator.

If rest, position, local pressure, and uniform compression do not cure the first; if the same measures fail to check the advance of the second and cause its gradual diminution in size; and if the third resists like treatment, the next step, I hold, should be the same in each. The surgeon should temporarily control the flow of blood through the part, cut open the swelling, turn out the clots, and if blood comes from the wounded artery—and in most cases, even if does not—at once twist or tie the vessel above and below the point of wound or rupture. Contrast this method with the Hunterian operation; in the latter the collateral circulation has been partially formed during the slow growth of the aneurismal tumor, consequently the main vessel can be occluded with but little danger of gangrene; the sac of the aneurism is filled with clotted blood, the result of rapid coagulation of its contents, or its walls are strengthened by the deposition of layer after layer of fibrin; in either case the arterial pressure is no longer able to dilate the walls of the tumor, and the sac speedily contracts. In wounded or ruptured arteries, the surgeon can never be sure, prior to an operation, that the bleeding may not come from a small branch instead of the main vessel; in the former case, closing the principal artery of the extremity would require the development of the collateral circulation in a part not prepared for such a step, thus incurring great risk of gangrene; in the latter it would obliterate the main vessel in two places and leave but little hope of saving the limb. By opening the swelling, or dilating the wound, not only is the true source of the hemorrhage reached, and its flow checked, but the accumulated clots are removed and the compressed tissues relieved, while all danger of inflammation, supuration or gangrene is obviated.

There is one form of arterial lesion in which no time should be spent in tentative measures. I refer to cases of fracture with puncture of an

artery. In such cases it should be the rule for the surgeon at once to seek the injured artery and ligate it above and below the puncture.

Secondary hemorrhage needs attention in this connection. In accordance with the principles referred to as regulating the control of arterial hemorrhage, it would, at first glance, seem that they require the surgeon to enlarge the opening through which the blood is flowing, or to cut down upon the bleeding vessel should there be no opening in the skin, and tie or twist both ends of the vessel above and below the bleeding point. But this is not really so. The proper course to pursue is first to determine the end of the artery that is open; if the blood is dark, the hemorrhage is from the distal end; if scarlet, from the cardiac extremity. In the former case pressure will suffice to control the bleeding; in the latter, in order to prove efficacious, pressure must be preceded by an operation. What is this operation? It is not enlarging the wound to tie the bleeding point, because the changes that have attended the casting off of the ligature have unfitted the end of the vessel to withstand pressure; the cord would cut its way through the softened tissues so soon as tightened. Again, the occlusion of the main channel at the ligated point, having by this time established new channels for the blood, we have in secondary hemorrhage two of the circumstances that favor the Hunterian operation—a diseased condition of the vessel at the site of the lesion, and a free collateral circulation. It is good surgery, therefore, to occlude the vessel at some point between the heart and the source of hemorrhage, but at some distance from the latter. By so doing a very striking result is obtained: the arterial pressure that before forced blood from the part, despite rest, position, local pressure, or general compression, is now removed by this procedure, and, although the open central end of the vessel remains unsealed, still, as the only blood that reaches it must find its way into it through the collateral circulation, any hemorrhage from it will present the appearance and have the characters of venous blood. In other words, while secondary hemorrhage from the distal end of an artery, the blood practically being venous, is controllable by pressure, it needs the Hunterian operation to effect the same change in the arterial blood flowing from the open central extremity. After this operation, however, the same measures that ordinarily control venous hemorrhage now suffice for the latter condition as well as the former.

In conclusion, I would summarize the matter in the following propositions:

II.—1.—3.

1. Bleeding from an accessible artery should be checked by twisting or tying both ends of the vessel.

2. Moderate hemorrhage from one not readily reached, should be controlled by rest, position, local pressure, compression, etc.

3. Severe hemorrhage from an artery not controllable by pressure, etc., requires that the vessel be sought in the wound and both ends tied or twisted.

(a) An important exception is to be noted in some cases of wounds of the hands or feet: the danger of damaging important structures may lead the surgeon to tie or twist the brachial or femoral rather than seek the wounded branches of the palmar or plantar arches.

4. In fractures, complicated by wound or rupture of a large artery, the surgeon should at once cut into the swelling, turn out the clots, twist or ligate the central and peripheral ends of the arterial trunk.

5. In pulsating tumors, following wounds or injuries of arteries, should rest, position, local pressure or general compression fail to check their growth or diminish their size, an operation should be performed, the tumor opened, clots removed and the vessel tied or twisted above and below the lesion.

6. When a wound or injury of an artery has led to extravasation, no operation should be performed, so long as rest, position, pressure or compression can restrain further hemorrhage. (a) An exception to this rule is to be noted in cases where the amount of blood in the tissues is so great as to threaten their integrity by gangrene, or where, after checking further increase, the above measures fail to cause a diminution in the size of the tumor, despite the length of time they have been employed.

7. If the extravasation caused by arterial wound or injury cannot be held in check and further hemorrhage prevented by position, rest, local pressure or general compression, the tumor should at once be cut open, the clots removed, and the vessel tied or twisted above and below the point of injury.

SOCIETY PROCEEDINGS.

THIRTY-SEVENTH ANNUAL SESSION OF THE OHIO STATE MEDICAL SOCIETY.

Held at Columbus, June 13, 14, and 15, 1882.

TUESDAY, JUNE 13.

The Society was called to order by the President, Dr. Starling Loving.

Dr. H. G. Landis read a paper on The Progress of Obstetrics and Gynecology.*

Dr. D. N. Kinsman read a lengthy paper on the Etiology of Consumption. According to Jaccoud, consumption is hereditary, inborn, or acquired. Heredity and acquisition only were treated of in this paper, in which the writer maintained the direct transmission of the disease, as well as the transmission of a morbid tendency toward it. The second point was supported by the citation of many cases where there seemed to be strong evidence that the disease was communicated by aerial contagion. Contagion from food was inferred as possible. Perlucht, or bovine tuberculosis, is a disease distinct from human tuberculosis. The same form of tuberculosis affects cattle as the human subject; hence, the consideration of tuberculosis in cattle becomes of importance to public health. The paper was illustrated by microscopic drawings from specimens of tuberculous lungs, which were used to enforce the distinction between catarrhal pneumonia and caseous or tuberculous pneumonia, when the stage of consolidation of the lung is reached.

In the discussion, Dr. Pooley stated that he had for a long time been convinced that phthisis was, under certain circumstances, contagious, and related a confirmatory case. He questioned the writer's statement that, because consumption is contagious, it cannot therefore originate *de novo*; chancroid is contagious, but it certainly can originate *de novo*, through filth, promiscuous intercourse, etc.

Dr. Reuben A. Vance, of Cleveland, read a paper on the Surgery of the Arteries.*

Dr. Halderman thought the writer had failed to impress the treatment of diffused aneurisms, or traumatic aneurisms, where it was necessary to

*Published in full in our present issue.

cut into the tumor and ligate both ends of the artery—Syme's operation. He thought one great danger in this operation lay in the risk of wounding the accompanying veins. Several years ago he had one of these cases, involving the point of termination of the femoral in the popliteal, in which he made the Hunterian operation successfully. The man is alive yet, but has a small tumor.

Dr. Pooley said that every surgeon should have a well-defined plan for meeting all emergencies, and aneurism belonged in this category, at least in this country. He did not quite see the pertinence of the criticism of the present nomenclature: "false aneurism" conveys a definite meaning, and is well enough retained. He believed in Mr. Guthrie's axiom, "Tie both ends of the artery," when possible. Syme's operation—so-called "old" operation—is an operation of necessity, not of choice. Thought ordinary care and prudence would prevent injury to the veins. Did not think there was much new, or could be much new, in the surgery of the arteries since the days of Hunter.

Evening Session.—This was occupied by a lecture by Prof. Edward Orton (late President), of the Ohio State University, on The Relation of the State to Public Health. The lecturer took for his text Franklin's aphorism, "Public health is public wealth," and also Disraeli's statement, that "the health of the people is the first duty of the statesman." He first spoke of the loss to the State by sickness, especially by epidemics, referring to the estimated loss of Philadelphia, during the small-pox epidemic of 1871-2, of \$24,000,000. With individual cases of sickness the State can have no concern, but in epidemics its power to act is universally conceded.

The lecturer sketched the growth of sanitary measures from the time of Moses, Plato, and Hippocrates, to the present, showing that during the fearful pestilences of the Dark Ages, "The curse causeless did not come." He thought the time was near at hand, which Dr. Benjamin Rush predicted, "when our courts of law shall punish cities and villages for permitting any of the sources of bilious and malignant fevers to exist within their jurisdiction.

He entered a plea for *system* in the making of sanitary improvements, and protested against the work being undertaken by fickle-minded, temporary, and changing municipal boards. The work must be planned by a competent civil engineer. He spoke of a trunk sewer, "in a principal street in a great city, that, like a gorged serpent, was larger in the middle than at either end;" of others many times too large for any possible de-

mand, which thus became mere reeking cesspools; and, worse still, of others built in villages for general purposes, before a water supply had been secured or even thought of.

He next spoke of the pollution of rivers, and the necessity of laws for their protection. No city thinks of those that live below it, the practical doctrine being, "the devil take the lowermost;" and he quoted with effect Coleridge's lines—

"The river Rhine, as is well known,
Washes the city of Cologne;
But, Oh! Ye gods and powers divine,
What then shall wash the river Rhine?"

He closed with a line of argument showing the importance of and necessity for a State Board of Health.

WEDNESDAY, JUNE 24.

Morning Session.—W. T. Corlett, M. D., L. R. C. P. London, of Cleveland, read a paper on the Etiology of Certain Cutaneous Affections. Eczema he regarded as a "superficial dermatitis due to an *irritation* of the sensitive filaments of the peripheral nerves," the origin of this irritation being either external, *i. e.* local, or internal, *i. e.* constitutional. Psoriasis he thought was a local disease.

Dr. N. P. Dandridge, of Cincinnati, read a report on the progress in Surgical Diseases of the Genito-Urinary Organs, in which he spoke quite at length of prostatic diseases and of Bigelow's operation.

Dr. Vance said he would not exalt Bigelow's operation, perhaps, as highly as the writer, but he regarded it as a good operation. The operation itself was, however, but the natural outgrowth of the operations that preceded it.

Dr. Miller, of Cleveland, thought that enlargement of the prostate was of more real importance than all the other troubles described. Prostatorrhoea, or chronic gleet, is due to a diseased gland, and its treatment by injections borders on malpractice, as liable to result in stricture or abscess.

Dr. P. S. Conner, of Cincinnati, said that cutting succeeded so well, that for himself, he did not care to change to crushing under ordinary circumstances. If he had a stone in his own bladder, he would prefer to be cut. Better results follow; he once saw an autopsy at which eight calculi were removed from a man's bladder, in whom lithotripsy had been performed seven times. Cutting would have removed these all at once. He

preferred rapid crushing to slow, but no one should attempt the operation until perfectly familiar with the instrument. For inflammation of the prostate he recommended *hot* water rectal injections, by means of a double canula, or even an ordinary syringe, the stream being directed against the anterior wall of the rectum.

Dr. S. C. Dumm, of Constantia, spoke favorably of electricity for hyperesthesia of the urethra.

Dr. P. S. Conner, of Cincinnati, read a paper on External Perineal Urethrotomy, in which he highly recommended the operation in cases of deep, impassable strictures.

Dr. Pooley said that external perineal urethrotomy was his favorite operation, and he was glad the writer advised it. The doctrine that "where water can come out, a bougie can go in," is not true either in theory or practice, and after failure with bougies the knife is the best means of relief and cure.

Dr. Vance said there was much to be said in favor of the operation advocated, but he preferred the internal operation. In the great majority of cases, a single filiform can be passed; by letting this remain for twenty-four hours, a No. 6 or No. 10 can be passed, and then internal urethrotomy can be performed, with a better result than that by the external incision.

Dr. W. J. Scott said he had several times failed with filiform bougies, but when he cut down he ordinarily had little trouble. In these cases he adopted the following method: pass a sound of fair size *to* the stricture; cut down, taking care to make an incision *smaller* than the end of the sound; withdraw the sound a short distance, and then with a small probe, working through the incision, find the passage, follow the probe with a director and then use the knife. Pass a catheter, which is to be left in for some hours, until inflammatory deposits are thrown out so as to correct the curvatures. He had never failed with this method.

Dr. Sidney Norton, Professor of Chemistry in the State University, read a paper on the Contaminations of Drinking Water. No drinking water is chemically pure. The impurities, however, are not harmful if they consist of mineral matters, like clay or sand, which soon subside, or of fresh organic matters, vegetable or animal. Neither are the lime salts nor the alkalis harmful, unless in excess. The popular taste prefers a water of this sort. Neither is water harmful if it contain the final products of organic decomposition, viz., carbonic acid, ammonia, and the oxides of nitrogen, unless in large amount. But all decomposing organic

matters are dangerous. One part in 1,000,000 will render water dangerous, as it may contain soluble and organized ferments, capable of multiplying a thousand-fold in a short time, and of inducing zymotic diseases. The writer accepted the conclusions of the London Board of Water Supply, that running waters are self-purifying, as are also those of deep wells and perennial springs.

Dr. Starling Loving, of Columbus, then delivered the President's Address. He recommended a fixed place of meeting, which would naturally be at Columbus, where could be erected a suitable building for meetings, and a library and museum founded. The Code of Ethics was then considered, and the opinion was expressed that when we consent to associate professionally with irregulars we shall not elevate but, on the contrary, degrade ourselves from the high position we have always occupied, to the level of a mere trade, for most of them use their name as a trade-mark only, and appreciate fully that it comprises their sole claim upon the public.

Of course, if we modify our Code so as to permit fraternization, however limited, with homeopaths, we shall be obliged to extend the same courtesy to eclectics, spiritualists, uroscopists, *et id genus omne*, including Lydia Pinkham and the "retired clergyman whose sands of life have nearly run out," for, in the language of the surgeons, the line of demarkation is not broad. The thought is not overly pleasant! It might be more so if what was done by the New York Society had been accepted as a concession and an expression of good will, but it was not. The homeopathist journals claim it as a great victory for their side, and as evidence that the regular profession is trembling for existence.

Finally, if we go with the New York Society, or rather the minority of that Society, who changed the Code to suit themselves, we must consent to be dropped like those gentlemen, from the fellowship of our own profession. "This morning, in adopting your new Constitution, embracing the Code of the Association, you declared against it. The thing is impossible. The American Medical Association, our Supreme Court, has unanimously declared against it."

The evils arising from the increasing use of non-official and proprietary medicines, were noticed, and the methods of introduction, by seductive samples and equally seductive agents, graphically described. The growing use of such remedies was deprecated.

The failure of the Board of Health bill to pass was deeply deplored, and the importance of the measure insisted upon. In this connection the

speaker referred to the poorly constructed and illy-ventilated State buildings, including the school-houses, which are so badly arranged in these particulars that myopia is rapidly increasing. He also spoke of the necessity of supervision in the location of towns, with their water supply and sewerage; of the adulteration of food; of protection against epidemics; of vital statistics, and of other matters properly coming under the control of a Board of Health.

In case of failure in establishing such a board, it was recommended that an attempt be made to have the State create a Board of Censors, to examine all who propose to practice, and "to stand between the people and the medical colleges." If both these plans fail, then the members of the Society should refuse to receive incompetent men as students.

The Address, though long, was listened to with the closest attention throughout.

Dr. S. C. Ayres, of Cincinnati, read a paper on Retinitis Albuminurica. After some general remarks, he referred to the comparative frequency of retinitis in cases of albuminuria. In 104 cases of albuminuria in the Cincinnati Hospital, during 1877, '78, '79, there were ten cases, or 9.6 per cent., of retinitis. Of these, five died, two were discharged improved, and three unimproved. He described the typical ophthalmoscopic appearance of the fundus, and called attention to the necessity of the frequent use of the test-tube and microscope. He stated that nephritic retinitis occurred most frequently in cases of small granular or contracting kidney.

Dr. Philip Zenner, of Cincinnati, reported a Case of Hemiplegia: Secondary Degeneration of the Pyramidal Tracts.

Dr. W. H. Mussey, of Cincinnati, next described the Treatment of Chronic Cystitis by a Curette, designed by himself for scraping the surface of the bladder.

The same gentleman also reported a case of Removal of Astragalus for Necrosis, in which his patient made an excellent recovery.

Evening Session.—Dr. J. R. Black, of Newark, delivered a popular lecture in the chapel of the Deaf Mute Asylum, on Preventing Diseases, after which the members and invited guests partook of a banquet furnished them by the trustees of the institution.

THURSDAY, JUNE 25.

Morning Session.—Dr. G. S. Franklin, of Chillicothe, read a paper on Public Charity and the Medical Profession. In this he dwelt especially

on the defective and unjust laws in Ohio relating to the care and medical treatment of the township poor.

Dr. E. B. Pratt, of Mt. Sterling, read an exhaustive paper on the treatment of some of the more common forms of inflammation of the knee-joint. In acute inflammation he recommended rest, secured by Buck's extension apparatus; abstraction of blood locally, by leeches, cups, or incisions; diminishing the supply of blood by compressing the femoral with a sponge; cold; pressure by bandaging joint over sponge. For erosion of the cartilages, use the actual cautery. After the acute stage has subsided, Sayre's knee-joint splint may be applied, so that the patient may be able to take exercise. Constitutional treatment from the outset, as needed. For the effusion, aspiration may be resorted to if necessary, but it should not be done merely for relief of pain, unless all other means fail. It will not shorten the acute stage. It should not be used when the acute stage is purulent; the cartilages or bone being necrosed, make a free incision. It should be resorted to when the acute stage begins to subside, usually during the fourth week. For sub-acute inflammation use Sayre's splint, iodine, the rubber bandage, aspiration. Chronic inflammation requires extension, the cautery, pressure, thorough drainage, removal of necrosed tissue, ankylosis in straight position—if motion is despaired of, and lastly, excision or amputation. Medicated injections into the joint are apt to do more harm than good, and Listerism is not recommended.

Dr. Pooley strongly recommended irrigation by cold water through rubber tubing. Thought pain from effusion an indication for aspiration. For pressure, preferred adhesive straps. Proper classification would be into those cases involving the synovial membrane, and those affecting the bone. The latter are generally tubercular, and essentially chronic. Should be treated by plaster-of-Paris splint; put a thick sole on foot of sound limb, furnish the patient with crutches, and make him exercise. Amputation is safer and better than excision. It is not true that any sort of a leg is better than an artificial one.

Dr. Hamilton thought aspiration might be regarded as a curative measure, in acute synovitis, and related a case. Irrigation by tubing is efficient, but laborous and requiring attention. Advised extension to overcome flexion, and fixation by plaster.

Dr. Garrison, of Utica, while sanctioning all that had been said, recommended *hot* water to reduce the inflammatory action.

Dr. Mussey, of Cincinnati, preferred Day's posterior splint. Leave

II.—1.—4.

joint exposed, and apply cold water or leeches. Aspirate, or open joint by valvular incision. If the limb is to be elevated, the surgeon must remember to slightly flex the leg, or else the joint will be pinched.

Dr. W. Morrow Beach, of London, read a paper on Achievements and Failures in Medical Art.

Dr. W. B. Davis, of Cincinnati, read a report on the Progress of *Materia Medica* and Therapeutics. Therapeutics was formerly based entirely upon experience; hence many of the triumphs of medical treatment in the past we now know were mere coincidences. Progress in therapeutics, like progress in the practice of medicine, must be based on a knowledge of anatomy, physiology, pathology and chemistry. To discover errors is to make progress. Modern therapeutics has done this, and in addition our knowledge of the physiological action of quite a number of drugs is now firmly established. Progress in this direction has been so rapid of late that even the present generation of physicians may live to see many of our present empirical methods of treatment supplanted by others founded on the solid rock of science.

Dr. Joseph Eichberg, of Cincinnati, read a report on the Progress of Laryngology. Two topics were embraced in this report, viz., the pathology of laryngeal phthisis and the identity of croup and diphtheria. The importance of early diagnosis was mentioned, and the means of making it by laryngoscopic examination described. Tubercular disease of the larynx may often be regarded as primary, simply because of our inability to recognize the early deposit of tubercle in the lungs.

The writer maintained the identity of croup and diphtheria, claiming that both the pathological and clinical features bear out such a view. He attempted to reconcile the differences seemingly existing between the two, and to show that they often bear the same relation to each other as do the mild and severe cases of an epidemic of any acute infectious disease, the differences in the symptoms being dependent upon the differences in function of the parts involved.

Dr. Geo. W. Garrison, of Utica, read a report on Cancer. He thought cancer was the result usually of a local injury, and he denied its hereditary transmission. It may appear at any age, but is most apt to attack the tissues at the time they are undergoing degenerative changes. Cancer cells cannot be differentiated from constructive cells; the caudate cell does not necessarily imply malignancy. As to treatment, he has found escharotics to give very favorable results in 35 cases.

Dr. Geo. A. Collamore, of Toledo, read a report on the Progress of

Medicine. He spoke of the experiments of Pasteur and their important relation to medicine ; of Koch's supposed discovery ; of pyrexia ; of the treatment of scarlet fever and diphtheria ; and of the salicyl compounds in rheumatism.

Dr. A. M. Bleile, of Columbus, read a paper on Digestion. This paper was based largely on original experiments. He condemned any attempt at using *ptyalin* in medicine, as its action is rendered *nil* in the stomach. Pepsin does little good in dyspepsia, unless accompanied by hydrochloric acid, or bismuth, which latter acts as a local stimulus. Pancreatic ferment is destroyed when taken into the stomach, hence it is useless as a remedy.

It being now late in the afternoon of the third day, the remaining papers were referred to the Publication Committee.

So much for the scientific and social aspects of the meeting.

The new Constitution and By-laws was presented, by the old committee, with certain suggestions as to changes and amendments, and the whole referred to a new committee, consisting of Drs. X. C. Scott, W. M. Beach, D. Little, J. B. Thompson and W. H. Mussey. This committee reported Wednesday morning, recommending merely a few verbal changes in the report of the previous committee, and the report was at once adopted without debate. Thus was removed what was feared would prove a source of contention and of great loss of time.

One thousand extra copies of Prof. Orton's Address were ordered printed, for general distribution.

It was decided to meet next year in Cleveland, at the time of meeting of the American Medical Association (June 6th), the idea being to merge the two meetings into one. A committee of five was appointed to confer with the Chairman of the Committee of Arrangements of the Am. Med. Ass.—Dr. X. C. Scott—in regard to a proper reception and entertainment of that Association at the meeting. This committee consists of Drs. Reuben A. Vance, A. C. Miller, J. C. Hubbard, W. T. Corlett and I. N. Himes.

OFFICERS The following officers were elected for the ensuing year: *President*, Dr. C. P. Landon, of Westerville; *Vice-Presidents*, E. Sinnet, A. C. Miller, N. Gay, W. B. Hedges; *Secretary*, Geo. A. Collamore; *Ass. Secretary*, M. F. Lee; *Treasurer*, T. W. Jones.

It was concluded to publish the *Transactions* of the current year in book form, and to include in the same volume the *Transactions* of last year.

The stereotyped resolutions, as to a State Board of Health, and of thanks to the retiring officers and to the Trustees of the Institution furnishing the banquet, were offered and adopted, and the Society adjourned.

WEST VIRGINIA STATE MEDICAL SOCIETY.

The Society convened for its fifteenth session at the Capitol building, May 24th. Dr. George Baird, of Wheeling, gave the welcome address on behalf of the local fraternity. Forty-one members responded to the roll-call, and fourteen new members were voted in. Dr. B. B. Leonard, delegate from the Ohio State Medical Society, was introduced, and responded in a few well-chosen words.

Papers were read as follows: "New Remedies in Surgery," by Dr. B. W. Allen; "New Remedies in Medicine," by Dr. A. L. Stifel; "*Quis Custodiet Custodes?*" Dr. J. M. Lazell; "State Medicine," Dr. Colley Shriver; "Retro-displacements of the Uterus, with Adhesions," Dr. D. P. Morgan; "State Health and Sanitary Science," Dr. T. B. Camden.

Evening Session.—This was devoted to the President's address, and an address by Albert L. Gihon, M. D., Medical Director U. S. N., on "Health, the True Nobility."

The address of the President, Dr. Jas. E. Reeves, of Wheeling, was quite broad and general in character. It opens with a eulogy of the late Dr. Hugh W. Brock, of Morgantown, one of the Censors of the Society. After which the year's progress in medical discovery is recounted, special mention being made of Koch's discovery. Considerable space is given to discussing the importance of a knowledge of sanitary science, and of diffusing that knowledge. This leads naturally to a consideration of the new State Board of Health, its origin, function and work during the year. Up to date, there have been registered 442 graduates, 358 "ten year" men, 101 licentiates.

We are pained to see that, under the caption "Cheap Diplomas," Dr. Reeves finds cause for complaint against one of the medical colleges of this State. We quote the following:

"On the 13th of last January an applicant for a medical certificate, a resident of West Virginia, came before the District Board at Wheeling and failed to pass a satisfactory examination within the meaning of the law. Ten days later, or about the 23d of January, he knocked at the door of the *Graduating Class* of the Columbus Medical College, and was admitted.

Within one month from that time he was graduated; and at the brilliant display at Comstock's Opera House, on the evening of the 24th of February, he received his diploma!

"I have it from an eye-witness that he presented to the faculty 'letters of recommendation from prominent gentlemen in West Virginia,' and that in the distinguished graduating class (which was spoken of by some of the professors as one of the brightest and best which ever came from that school) 'one man was graduated who did not know what the iris was, nor the pupil; could not locate the mitral nor tricuspid valves—placed the valvulæ conniventes in the *brain*, and the ileo-cecal valve in the *rectum*!' 'There were several of that sort, but they are just now as much doctors (in Ohio at least) as you or I.'

"What an impressive, never-to-be-forgotten scene at the commencement! The stage decorated with beautiful flowers—the orchestra discoursing sweet music, and stirring the hearts of the audience—the faculty, in double file, marching upon the stage—the 59 graduates taking their places in the front rows of the parquette—and the applause! and the bouquets! which greeted the new doctors!! It was most appropriate that a *prayer* was then and there offered."

The address closes with a most earnest protest against the action of the New York Society in reference to its notorious "New Code."

Dr. Gihon's address is devoted solely to considerations of sanitary matters and measures, and is unusually interesting.

Second Day.—Papers were read as follows: Dr. John Frizzel, "Epidemics and the Causes of Disease"; Dr. Jepson, "Clinical Note on Typhoid Fever"; Dr. Hall, of Mannington, "Case of Placenta Previa".

Afternoon Session.—Drs. B. B. Leonard, of Ohio, and A. L. Gibon, of the Navy, were made honorary members of the Society. The reading of papers was then continued: Dr. E. A. Hildreth, "Meteorology and Disease"; Dr. E. C. Myers, "Cases of Ovariectomy"; Dr. C. F. Ulrich, "Drinking Water and Health"; Dr. L. D. Wilson, "Intestinal Occlusion".

Grafton was selected for the next meeting.

Election of officers resulted as follows; President, Dr. D. B. Allen, of Wheeling; Vice-Presidents, Dr. Colley Shriver, of Bethany, Dr. Grant, of Cameron, and Dr. Manown, of ———; Secretary, Dr. S. L. Jepson, of Wheeling; Treasurer, Dr. J. A. Campbell, of Wheeling.

Before adjourning, resolutions were unanimously adopted condemning the action of the New York Society in adopting its present Code.

The Society was entertained by a concert, given in honor of the occas-

ion, on the first evening, and an elegant banquet was served the second evening at the St. James Hotel.

The meeting was in every way an entire success.

SELECTIONS.

SURGERY.

CASE OF DRY GANGRENE FROM LOCAL APPLICATION OF CARBOLIC ACID.—(J. B. Garrison, M. D., Garretson's Landing, Ark.).—About the middle of February last, a daughter of Dr. Childress, of Williamette, Ark., consulted her father as to an onychia in process of development on her right index finger. She was directed to "apply carbolic acid," but instead of applying a few drops to the affected part, she wrapped the entire finger as far as the second joint with several folds of linen and poured on it to saturation pure carbolic acid, liquified, and allowed it to remain in *statu quo* all night. Next morning the bandage was removed, and on the third day after the occurrence, when I first saw it, the finger as far as the second joint was as black as jet, cold, perfectly anesthetic, wrinkled and shrivelled, with sulci apparently clinging to the bone; hard as wood; in a word, actually mummified, with a line of demarkation entirely around the finger, indicating a complete separation of the dead from the living tissue. Although there seemed no possibility of saving the finger, as it had actually lost every vestige of vitality, yet I directed a small rubber band to be tied around the finger, near the metacarpo-phalangeal articulation, sufficiently tight to obstruct the reflux of venous blood without repressing the arterial supply. This was applied for five or ten minutes every hour and kept up continuously for more than two months. The tissues of the finger gradually yielded to the mechanical pressure of the blood, and the digit resumed its shape and functions, except that it was entirely denuded of integument. The old skin was allowed to remain as a protective, and warm, moist poultices with oil and glycerine were constantly applied to soften the tissues. The fortunate result of this case is an additional argument in favor of the principle of conservatism in surgery which should obtain in all similar cases.—*Western Med. Reporter*.

[Several cases similar to the above have been recorded during the past

two years, in which carbolic acid locally used has produced a condition closely resembling dry gangrene. In none of these cases, however, was any attempt made, if we remember correctly, to save the parts, Dr. Garrison's success in his case will lead to a more active line of treatment in the future.—B.]

ALCOHOL IN BURNS AND SCALDS.—Saturate a soft piece of fabric with alcohol, lay it over the burn, then cover it with cotton or finely picked oakum. This is the most cleanly dressing that can be adopted. It may be thought that alcohol applied to a burn will produce more pain; but try it, and you will be agreeably surprised to observe how quickly it will *allay* the pain; subsequently disturb the dressing as little as possible; wet the dressing occasionally with alcohol, and the result you will find better than by any other method.—Borck, in *St. Louis M. and S. Journal*.

LOSS OF MOTION IN CHILDREN,—This is an affection which occurs often. I will illustrate a case or two, of which I can find no mention in any book,

A child is pulled, dragged or lifted by the arm in a quick manner, for example, over a gutter. The child cries aloud, drops his arm down after it is released, and has lost completely the motion of that arm for the time being.

The parents becoming alarmed, send for a doctor to ascertain what is the matter. He examines it all around, and, like many others, concludes because there is a loss of motion, "there must be a fracture, though he is not sure, because it is a child, and it is hard to tell what the real trouble is in a child." I have been sent for more than once under such circumstances to set a broken arm, but could not find the fracture; a simple loss of motion comprehends the whole of the affliction.

A second case, a child falls, the nurse jumps and runs to pick up the poor darling, in most cases by one hand, with a quick motion, a little anger probably mingled with it, "of course it is always the nurse, mothers never commit such blunders!" The child screams bitterly, his arm drops down, it cannot move it; follows excitement in the previous peaceful household. I have been sent for frequently in such cases, either by parents or by request of the family physician, to reduce a supposed dislocation; but no dislocation is to be found, simply loss of motion. Fractures and dislocations of course can and are produced in such manner, and sometimes separation of the epiphysis.

But it is to the loss of motion to which I call your attention; it is fortunate, however, for the little patient and fortunate for those concerned, that you can console them with the assurance that the limb will be restored to its proper position in time, almost without any treatment, except rest and some mild embrocation, providing you find sensation unimpaired; one should carefully examine and satisfy himself of this, else the case may then assume a more grave aspect.—*Ibid.*

MUSCULAR ACTION IN THE PATHOLOGY OF HIP DISEASE.—In the July number of the *New York Medical Journal*, Dr. A. B. Judson, Orthopedic Surgeon to the Out-Patient Department of the New York Hospital, discusses some points in the morbid anatomy of hip disease, with special reference to the supposed effect of muscular contraction in promoting the progress of pathological changes in the articular structures. A careful review of the most important observations on record leads him to the inference that the crowding of the articular surfaces together by muscular action has no such effect. What mainly points to this inference is the fact that the primary lesions are not usually to be found in the superficial structures that enter immediately into the formation of the joint, but rather in the cancellous texture of the bones. This conclusion, however casts no doubt on the utility of the extension treatment, but simply leads to this interpretation of its beneficial action: Aside from the fact that we are compelled, empirically, by reason of its anodyne quality, to use traction, there is ample rational ground for its use. Traction, however applied, is unavoidably accompanied by fixation. The most efficient apparatus for the application of traction is, at the same time, the most efficient means known to surgery for the solution of that difficult problem, the immobilization of the hip joint; and, finally, immobilization is indicated by every feature of the pathology as revealed in morbid specimens.

THE REDUCTION OF OLD HERNIÆ.—Ordinarily an old and large hernia is left pretty much to itself. Palliative measures alone are attempted. Yet the positive and continuous inconveniences remain, sufficient in many cases to render life a burden, and should be a constant incentive to renewed efforts. M. Thiry, in the *Bulletin de l'Academie Royale de Belgique*, has lately shown us what may be justly called a new method of treating such tumors, by frequently repeated attempts at taxis with compression during the intervals. The patient was a man of forty-two, whose hernia measured sixty-seven centimetres in circumference.

The intestines had "perdu droit de domicile" in the abdomen and were all in the scrotum, and produced a considerable dysuria. Undismayed by the size and age of the hernia, M. Thiry repeated the taxis twenty-four times, at unequal intervals extending over nearly three months. At each sitting more or less of the hernia was reduced, and, once reduced, was retained in place by an elastic bandage. After complete reduction, a truss with a very convex pad penetrating into the ring was applied. At the end of some months, the reduction was still effectual, the abdomen had resumed its usual rotundity, and urination was readily accomplished. Life had again become desirable. Of course in very many cases the adhesions are such as to forbid the hope of success. But no such hernia should be abandoned without at least patient and repeated trials.—*Phil. Med. News.*

TREATMENT OF BULLET-WOUNDS.—In a report made to the Societe de Chirurgie relative to fractures by pistol balls (*Lancet and Clinic*) Dr. Verneuil declares that for ten years he has always abstained from intervention in wounds and fractures produced by fire-arms, and he has always been fortunate in such abstention. He is altogether of the opinion of those who think that the part in which the wound or fracture is situated should be immobilized as far as possible, and no attempt made to find the missile. In regions where this immobilization cannot be effected in a perfect manner, as in the chest or abdomen, he applies upon the wound a bit of colodionized gauze, and surrounds the region with a bandage agreeably tightened. Drs. LeDentu and Chauvel expressed similar views.

THE TREATMENT OF EMPYEMA.—Dr. Hobson presents a very valuable and practical paper upon the treatment of Empyema, based upon an analytical study of one hundred and twenty cases, which occurred in London Hospitals. Eighty-six cases were in children under thirteen years of age, and his deductions as to treatment are chiefly drawn from an analysis of these cases. His conclusions may be briefly stated as follows :

Free incision in children, taken collectively, gives a mortality of 27 per cent., but antiseptic treatment gave much the best results. In the antiseptic cases the mortality was only 12.5 per cent. and the recovery much more speedy. Free incision in adults was pretty successful, but one would hope that with antiseptic precautions it would be far better. Tapping in children is very often successful. Although tapping will often not be sufficient to cure the disease, yet we have the positive evidence

that sixteen cases out of a total of forty-three got well with this operation alone. The results of tapping in adults are not favorable so far as they go. Dr. Ewald had six deaths in eight, presumably in adults mostly. Subaqueous drainage had a mortality of 43.8 per cent. in children. In children and adults together the mortality was 45.8 per cent. The subaqueous drainage had to be followed up by free incision in some cases. As for the expectant plan, I think it should be utterly discredited.

The rule which I would venture to formulate, then is this: In children tap once, twice, or more frequently if the child goes on well, but if it does not get on, or if the discharge is fetid from the first, or becomes fetid, open the chest freely near the angles of the ribs and use *strictly* antiseptic precautions. In adults I would open antiseptically from the first. Always before opening the chest, of course, and always where there is any suspicion of fluid which may be purulent, I would make an exploratory puncture, not with too fine an instrument.

Dr. Hobson does not anywhere state what he understands by the "antiseptic treatment" of empyema. This is certainly, in the present transitional state of antiseptic surgery, an unfortunate omission.—*Lancet*.

NELATON AND HEMORRHAGE.—The saying of Nelaton is often quoted: "If you have the misfortune to cut a carotid when performing an operation, remember it takes two minutes for syncope to supervene, and as many more before death occurs. Now, four minutes are four times the time required for a ligature, provided you don't hurry yourself. Never hurry yourself."

FOREIGN BODIES IN THE AIR PASSAGES.—Dr. J. R. Weist, of Richmond, Indiana, read a paper on this subject, at the late meeting of the American Medical Association. The paper was statistical, and contained generalizations from over one thousand cases which he had collected. The conclusions to which he had been led differed from those of most text-books, but were founded upon a careful comparison of the results obtained by prompt surgical interference and those which followed spontaneous expulsion. His conclusions were:

1. When a foreign body is lodged either in the larynx, trachea, or bronchi, the use of emetics, errhines, or similar means should not be employed, as they increase the sufferings of the patient, and do not increase his chances of recovery.

2. Inversion of the body and succussion, though sometimes useful, are

dangerous, and should not be practiced unless the windpipe has been previously opened.

3. The presence simply of a foreign body in the larynx, trachea, or bronchi, does not make bronchotomy necessary.

4. While a foreign body causes no dangerous symptoms, bronchotomy should not be performed.

5. While a foreign body remains fixed in the trachea or bronchi, as a general rule, bronchotomy should not be practiced.

6. When symptoms of suffocation are present, or occur at frequent intervals, bronchotomy should be resorted to without delay.

7. When the foreign body is lodged in the larynx, there being no paroxysms of strangulation, but an increasing difficulty of respiration from edema or inflammation, bronchotomy is demanded.

8. When the body is movable in the trachea, and excites frequent attacks of strangulation, bronchotomy should be performed.

BUBOES AND LYMPHADENITIS GENERALLY.—Dr. M. K. Taylor, U. S. Army, strongly recommends (*Am. Jour. Med. Sci.*) the injection of an 8-16 gr. solution of carbolic acid in the abortive treatment of these affections. He injects about 20 minims, repeating the operation a second or third time if necessary.

OBSTETRICS

LANDMARKS IN THE OPERATION OF LAPARO-ELYTROTOMY.—Dr. Wm. M. Polk, Professor of Obstetrics in the University Medical College, New York, recently demonstrated certain anatomical points bearing upon the operation of laparo-elytrotomy, before the New York Obstetrical Society. The remarks made by Dr. Polk on that occasion appear in an amplified form in the May number of the *New York Med. Journal and Obstet. Review*. The specimen shown, taken from the body of a woman who had been murdered in the seventh month of pregnancy, was a section showing the relations of the pelvic contents during the latter part of gestation, and especially the course of the ureter. Practicing the operation upon this and other cadavers, the author has found that the ureters do not follow the pelvic wall to a point near the ischial spine, as in the non-pregnant condition, but that crossing the pelvic brim at the common iliac bifurcation, the left just behind, the right just in front of that point, they descend into the canal to the brim of the bony pelvis, the point being about the

synchondrosis. In this course they accompany the internal iliac artery, the right in front of the vessel, the left crossing it obliquely. Reaching the bony brim (the ilio-pectineal line), they leave the pelvic wall, emerging from beneath the base of the broad ligaments (in pregnancy about on a level with the pelvic brim, and carried back on a line with the synchondrosis), and take a course downward, forward, and somewhat inward, passing about midway between the pelvic wall and the cervico-vaginal junction, but approaching very closely the antero-lateral wall of the vagina, as they turn more decidedly inward, on a lower plane, to strike the base of the bladder three-quarters of an inch below the cervix, terminating in the bladder at a point (the subject being on the back) just two inches below the spine of the pubes. A line drawn from the spine of the pubes corresponds in the main to the line of the ureters. Along this line they have the following relations to the pelvic brim (in the recent state): At the bifurcation, half an inch below; at the extremities of the transverse diameter of the pelvis, about an inch; and at the spine of the pubes, two inches below. As a whole, the tubes in the pelvis are situated upon a higher plane, than in the non-pregnant condition, having been carried slightly upward while being separated from their close relations with the pelvic wall by the ascending uterus. How far they may be elevated in a case of extreme pelvic deformity with a pendulous abdomen, and the uterus correspondingly displaced, the author is unable to say, but thinks it probable that the bladder being empty and not dragged upward, thus preserving the normal position of the vesical-end of the tubes, the displacement would not be such as to bring any part of them above the points indicated.

Another matter which Dr. Polk took occasion to investigate was the ground of the objection to operating upon the left side. In view of the strong probability that the operation can be done on the same side but once, this, he remarks, is a very important question. He did the operation upon the left side, the vessels being injected with plaster and the rectum distended. He found that the rectum offered no such obstacle as is commonly supposed, and that the operation was as feasible upon one side as upon the other. After the operation the organ was carefully examined and found in no way disturbed. In looking at its position this was readily accounted for; it lies behind the broad ligament. In entering and leaving the pelvic canal we cross the brim between the base of the broad ligament and the posterior surface of the bladder. This latter is about on a line with the ilio-pectineal eminence, while the former is as far back as the synchondrosis. Here is ample space for manipulation and extraction.

The important structures that Dr. Polk regards as most likely to suffer are the vessels going to the uterus through the broad ligament. These, by being stretched and dragged upon in extraction, might be torn, if the sides of the incision were not carefully supported in cases requiring a powerful traction.

THE GREAT FREQUENCY OF CARDIAC MURMURS IN THE PUERPERAL STATE.—(Dr. John Williams.) The observations were made on 111 consecutive cases. Murmurs were heard in 84 cases, or about 75 per cent. The great majority of the murmurs were situate over the right heart. There were two cases of undoubted structural disease. The remaining great bulk of the murmurs are here dealt with. The patients who possessed a murmur for the most part did not suffer from symptoms referable to the heart. The time of the murmurs was invariably systolic. The murmurs are divided into three sorts. The first resembling an ordinary endocardial murmur, was most numerous; was of blowing character, soft, usually low or medium-pitched, fairly long and heard with almost every cardiac beat, and presented but little variation during the course of its existence. The number of these was 51; 36 were loudest over the tricuspid area, 8 over the mitral area, 6 over the pulmonary, and 1 over the aortic. By tricuspid area is meant the fourth left space, just a little to the left of left edge of sternum, there or thereabouts. The murmur was conducted to a variable extent. The duration of the murmur was variable. Most commonly the murmur was first heard a day or so after delivery. The mechanism of the murmur is discussed. The most novel and interesting, the "tricuspid" murmur, is believed not to be due to tricuspid regurgitation. No definite conclusion is come to as to the mode of production. The second kind (friction-like), was almost absolutely non-conducted, was heard over a very small area just above and to left of ensiform cartilage. The murmur seemed superficial, was high-pitched and stiff in quality; was not audible with every cardiac beat. This sort was heard twenty-nine times. The mechanism is probably exocardial friction. The site would about correspond to the white patch which may be seen on the front of the right ventricle. The third kind of murmur, the least numerous, the most capricious, was remarkable for its loudness, was very inconstant—*i. e.*, not heard with every cardiac beat, and was very transitory; its area of audition was remarkably limited; it was most frequently heard over one or the other base of the heart; it commonly went with an excited action of the heart associated with pyrexia or

mental emotion. Besides pyrexia, excitement, anemia, this murmur was sometime associated with rales in the chest and with a cough, but no sputa. The quality of the sound varied. In many cases it resembled the sound evolved when a piece of silk tightly stretched is scratched with the nail; or like the sound heard when pressure is made on the carotid in anemic cases. Sometimes the sibilant rale was almost exactly imitated. The murmur was in all cases heard when the breathing was stopped. The mechanism of this murmur is discussed. The murmur was heard sixteen times. The mode of generation of murmurs is regarded as very puzzling. All the murmurs of the second and third kinds, and a majority of the first kind, were temporary phenomena. Murmurs in the puerperal state are (for the most part) not indicative of the appearance of serious cardiac lesions.—*London Lancet*.

CRACKED NIPPLES.—*Le Paris Medical* publishes the following formulæ :

- | | | | | |
|--------|----|-------------------------------------|----------|----|
| No. 1. | R. | Cosmoline..... | 3 xiiss. | |
| | M. | Liquid balsam Peru..... | 3 i¼. | |
| No. 2. | R. | Oxide of zinc..... | 3 i½. | |
| | | Cosmoline..... | 3 x. | M. |
| No. 3. | R. | Glycerole of starch..... | 3 viiss. | |
| | | Oil of cade..... | mxlv. | M. |
| No. 4. | R. | Cocoa butter..... | 3 iiss. | |
| | | Oil sweet almonds..... | 3 ss. | |
| | | Extract of rhatany..... | mxv. | M. |
| No. 5. | R. | Gutta percha..... | 3 j. | |
| | | Pure chloroform, q. s. to dissolve. | | |

By anointing the excoriations with this a slight film is formed, which will not become detached, even after sucking.

DEATH AFTER OVARIOTOMY DUE TO PREVIOUS TAPPING.—Mr. Lawson Tait, drew attention to the fact that amongst the last hundred ovariectomies (for cystoma) which he had performed there had been only three deaths. In all the deaths had been due to the formation of a firm white clot, which started from the point of ligature of the pedicle and slowly traversed the venous system till it reached the heart, death ensuing in from thirty to forty hours after operation. The symptoms which preceded death were swelling of the legs, rapid rise of pulse, and its disappearance from the extremities some time before death; breathlessness ending in suffocation, and slight delirium. He had several such deaths, but not one in a patient who had not been previously tapped. His explanation was that the repeatedappings deprived the blood of

some element, or elements, included in the infinite variety of albuminous substance found in ovarian cysts, the deficiency of which predisposed to coagulation of the blood. The author thought that no case of ovarian tumor should be tapped till previous abdominal section had shown that it could not be removed. He believed if this rule was followed the mortality might be reduced to less than 1 per cent. if cases were operated on early. As long as the clamp gave a mortality of 25 per cent, it was right to stave off by all possible means so fatal an operation as ovariectomy.—*London Lancet.*

SIR WILLIAM MAC CORMAC'S patient, from whom he recently removed the uterus through an abdominal incision for cancerous disease, was, five weeks after the operation, quite convalescent. Her recovery had been retarded by an attack of bronchitis, probably caused by unavoidable exposure at the operation, but no other untoward symptoms had arisen.—*London Lancet.*

INDUCED ABORTION. METHOD OF OPERATING.—J. Ashfeld (*Archiv. f. Gynék*) recommends the use of tents with blunt ends, continued till the membranes present. He aims thus to expel the ovum entire. This method, conjoined with the use of antiseptic injections, he prefers to puncture.

ANCIENT PRIMIPARA.—Oswald reports a case, in *Brit. Med. Jour.*, April 29, '82, in which the mother, aged between 46 and 47 years, two years married, gave birth to a large male child. Forceps was used. Mother and child both did well.

THE CORPUS LUTEUM.—At a meeting of the Obstetrical Society, of London, Dr. W. A. Popoff, of Pensa, read a paper on this subject. In it he described the case of a prostitute, aged 21, dying of prussic acid poisoning, in which he found a fully ripe corpus luteum, although the woman was neither pregnant nor menstruating. The President (Dr. Matthews Duncan) said it was important to have the view confirmed that a corpus luteum, having all the characteristics of that met with in pregnancy, might occur in women who were neither pregnant nor menstruating. He had seen such a corpus luteum in an aged woman who was believed to be salacious, and he had dissected cases of pregnancy where there was complete absence of corpus luteum.

IS THE OVARIAN CELL PATHOGNOMONIC?—The accurate diagnosis of ovarian tumor is of vital importance, as mistakes are by no means rare, even among our most skilful diagnosticians. In the *American Journal of the Medical Sciences*, for April, Dr. W. A. Edwards published an account of some researches made in the Pathological Laboratory of the University of Pennsylvania, bearing on the value of the ovarian cell as a diagnostic point, from which he concludes :

1. The ovarian cell is not diagnostic of the ovarian tumor.
2. We may have a fluid from an ovarian tumor entirely devoid of the ovarian cell.
3. On the other hand, we may have an abdominal fluid which is not ovarian, presenting the cell in great abundance.
4. With the present state of our knowledge, the accurate microscopical diagnosis of ovarian dropsy is impossible ; the most distinguished ovariologists always make their first incision an exploratory one.

INTERESTING FACTS.—During the year immediately preceding that in which Listerism was first introduced, there were performed in the Woman's Hospital in this city, nine operations of ovariectomy, with nine deaths. Per contra, during the first year after Listerism was introduced, there were thirty-three operations for ovariectomy performed in this hospital, with three deaths. Without Listerism a mortality of 100 per cent. ; with Listerism a mortality of 9.1 per cent. *The last operations were performed in the new wing.—Amer. Med. Weekly.*

[The explanation, it strikes us, is to be found, not in Listerism, but in the last sentence, which we have italicised.—B.]

MEDICINE.

FOR INTERTRIGO.—Dr. B. A. Thomas of Rushville, recommends for this complaint, an ointment of vaseline and quinine.

NIHILISM.—In Heitler's ward I was shown a case of pleurisy with large effusion. When I asked for treatment, he said the patient will get no medicine. And although the chest was bulged out enormously, he would not tap because, he said, it was bad practice. The patient did well. They give no medicine for pneumonia, except "may be a little ipecac." You would be amazed at the number of doctors I meet here who are skeptical as to the efficacy of medicine.—McClelland, in *Med. Times*.

PRODROMATA OF PHTHISIS.—Dr. Coiffier (*Lyon Medical*, December, 1881) believes that when a clean tongue co-exists with a pulse of eighty-five it is an almost certain prodrome of pulmonary phthisis. When found in persons between eighteen and thirty years of age, who seem to be in excellent health, he regards such co-existent symptoms as evidence that tubercular deposit has already occurred.

CODEIA BETTER THAN MORPHIA.—Dr. Garrison (*Western Med. Reporter*) claims that numerous comparative therapeutic tests in his practice with morphia and codeia warrant the following conclusions:

1. That codeia is a greater cardiac stimulant than morphia, is indicated by the greater force and volume of the pulse following the administration of the former.

2. It is a more powerful diffusible stimulant, elevating the temperature and exciting the capillaries. Large doses produce an intense itching, with an erythematous redness of the skin, thereby indicating its use in all internal congestions, save perhaps those of cerebral or spinal origin.

3. It does not check the secretions to such an extent as morphia. It is therefore indicated when it is desired to avoid locking up the liver, constipating the bowels, or lessening expectoration.

4. It is greatly less dangerous than morphia, no lethal dose having been recorded, yet so potent an agent should necessarily be exhibited with due caution. Its comparative safety recommends its use in infantile therapeutics where morphia is so rarely tolerated.

5. It is never followed by the intense nausea which so often contraindicates the use of morphia, and frequently no unpleasant after-effects are noticed referable to its exhibition.

6. There is less danger from the induction of the opium-habit from repeated doses than is the case with morphia, which should be a matter of serious consideration in making a choice between the two.

The sulphate is the form to be preferred, because of its ready solubility. The dose is about double that of the sulphate of morphia, but it may be increased with safety to a much greater extent than the latter; the objection to large doses being the excessive itching which is produced, together with the intense erythema, both of which disappear coincident with the elimination of the medicine.

It is an excellent adjuvant in combination with other anodynes, such as chloral, the bromides, hyoscyamus and Jamaica dog-wood, adding to their efficacy and modifying their action desirably.

II.—1.—6.

EDITORIAL DEPARTMENT.

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THE STATE SOCIETY MEETING was, probably, all things considered, the best that has ever occurred in its history. Remarkably little time was occupied in legislative or miscellaneous business, but every session was commenced promptly, filled full of papers, and continued until the physical needs of the members compelled an adjournment. The very full synopsis of the proceedings which we publish is taken, almost entirely, from the columns of the *Philadelphia Medical News*, which journal has shown unusual enterprise in securing full reports from the Societies of all the States.

Notwithstanding some predictions to the contrary, the President proved a most skillful presiding officer, and the success of the meeting was in large part due to his executive ability and personal efforts in getting papers.

AT A MEETING OF THE PUBLICATION COMMITTEE, soon after the adjournment, three innovations were, at the suggestion of the chairman, unanimously adopted. 1st. To give to each author fifty neatly bound reprints of his paper. 2nd. To procure for each paper any necessary engravings, provided the drawings were furnished by the author. 3d. To allow each author to publish his paper in any medical journal he saw fit, *provided* his paper were examined and approved by the Committee, and that he furnish a written or printed copy for the Committee within thirty days after adjournment.

If any further inducement—save an actual money consideration—can be offered to encourage contributions, the Committee would be pleased to learn of it. Of course, the members will get all the papers in the usual

volume of *Transactions*, while the authors of valuable papers will be enabled to secure for them the most available and extensive circulation they can command.

Moreover, as by the new Constitution the Committees are rendered practically permanent, the action taken by the Committee this year will not be likely to be set aside next year.

It may be said that the Society cannot afford to go to the expense of reprints and engravings: such a statement would be incorrect, but even if true the solution of the difficulty will be found, not in cutting down the cost of the annual volume, but in increasing the assessment. The present assessment, while it has been ample for several years, is ridiculously low and much less than that in similar organizations in other States.

It is said that the post-graduate faculty of the medical department of the University of New York, which recently resigned in a body, are about to open a new medical college, organized as the medical department of Cornell. An entrance examination will be required, and the graded course of three years will be adopted, an examination being had at the end of each year. The withdrawing faculty consists of Profs. Roosa, Hammond, Gouley, Sturgis, Piffard, Stephen Smith and Little.

GUITEAU.

The last scene of the tragedy has been acted, and an insane man hung. That the man was insane we have never questioned; but that he was therefore irresponsible does not by any means necessarily follow. The line of irresponsibility does not correspond with that of insanity, and we are strongly of the opinion that the execution of Guiteau will deter many a "crank" (we are thankful for the coinage of that word) from a similar act, while an opposite termination of his miserable career would have strongly tended to produce the opposite result.

While it may be true that it is better that ten guilty men escape than that one innocent person suffer, this axiom can not, at least to the popular mind, be made to apply to a person confirmed in his insanity, and who is a nuisance to himself, his friends and the community.

As to the autopsy, we have little to say. That nothing particularly abnormal was found in the brain, proves nothing; nothing abnormal is found in the brains of a great majority of the insane.

There was, perhaps, a little poetic justice in letting Lamb make the examination, but aside from this he seems, from the published reports, to

have possessed no special qualifications whatever for the important trust. It would have been a coarse lesion, indeed, that would not have escaped his inexpert and bungling procedure.

Another bitter tirade from Gail Hamilton on the "Slipped Noose", *a la* that on the "Spent Bullet", will, however, now be in order.

THE Illinois State Board of Health, in which is vested the sole power of granting certificates to physicians to practice within its limits, has recently resolved that, after the usual session of 1882-83, no medical college shall be considered "in good standing" unless the following requirements are enforced: First, a preliminary examination or its equivalent; second, instruction (and examinations *passed*) in the seven ordinary branches, and also in Hygiene and Jurisprudence; third, actual (not merely nominal) attendance upon eight-tenths of the lectures, etc.; and, fourth, dissection during two courses, and hospital and clinical instruction for two terms during the three full years of study demanded. After next year, therefore, the graduates of medical colleges whose curriculum does not embrace these requirements, cannot practice in any part of Illinois on the strength of their diplomas merely, but must pass an examination before the Board of Health to test their knowledge in accordance with its regulations.

"CEREAL FOODS UNDER THE MICROSCOPE."

Sometime last January, Dr. Ephraim Cutter, of Boston, who has been trying so hard to make us believe is his so-called discovery of the germs of consumption in the blood, published an article in Gaillard's *Medical Weekly*, in which he claimed to show that nearly all the advertised "foods" contained, as shown by the microscope, little or no gluten, and hence led to the inference that they were fraudulent.

Not having much confidence in Dr. Cutter, on general principles, we concluded to defer calling attention to his article until his results should be either confirmed or shown to be false. Some of our exchanges, however, have not been so cautious, and the article has had a wide circulation.

But now come Dr. Jas. G. Richardson, Professor of Hygiene and Demonstrator of Histology in the University of Pennsylvania, in the *Philadelphia News*, of June 24, and shows the glaring errors in the article alluded to. He says that if Dr. Cutter will take some of one of the fine flours he asserts "contain no gluten," mix it with water into a dough, let it stand for half an hour, and then stir it in a porcelain capsule, with

successive portions of water, until the starch is washed away, he will find the adhesive fibrillated gluten left nearly pure, in the proportion, after drying, of from seven to twelve per cent.

As additional evidence, let Dr. Cutter separate the gluten in this way from a sample of whole wheat flour, and then examining under his microscope one of the bran particles which are deposited with the starch from the water used in washing the glutinous mass, he can enjoy looking with one eye at his hypothetical gluten cells, and with his other eye at the *real gluten*, prepared from the same identical sample, by the method long known to sanitary scientists, and of which the masticating process, used as a test for wheat by millers, and even by farm boys all over the country, is but a homely modification.

Whether Dr. C. will make these experiments, and then gracefully acknowledge his former errors, remains to be seen.

WANTED—AN EDITOR!—The American Medical Association, at its last meeting, did two things: it most emphatically repudiated the action of the New York Society in adopting its new code—as we had all anticipated, and it decided to publish a medical journal, after this year, in place of its usual volume of *Transactions*. To carry out this idea, a committee was appointed to secure an editor, and to make other necessary arrangements for the *accouchement*. It will not be difficult to get the necessary numbers of subscribers; advertising space will be in high demand; contributions will be numerous, and valuable if well paid for; but where is the editor?

We might have nominated Shrady a year ago, but by his record on the Code he has committed *hara-kiri* most effectually. There is plenty of other good material in New York, but it is all rendered unavailable by the attitude of the State Society. Boston is, of course, full of editors, but it is too far east, too far removed from the center of medical civilization, and its attitude toward the Association has, of late years, been too lukewarm to enable it to reasonably hope for the honor. Philadelphia comes next, and the chances are all in its favor—even if it did not get the award of printing the new Pharmacopeia. It is central, contains two first class schools and several first class medical journals, is intimately connected with the history of medical science and progress in this country, as well as the history of the Association itself, and contains ample material for both an editor-in-chief and associate editors. For the former position we nominate I. MINIS HAYS, editor of the *American Journal of the Medical Sciences*.

"Koch's Bugs."—The N. Y. *Record* thinks that Koch's experiments have excited much more talk than they deserve, and confesses to some skepticism in regard to the facts and still more as to their "far-reaching significance." New York microscopists have not yet been able to find the bacilli.

MRS. NICKLEBY'S REMEDY FOR A COLD.—"I had a cold once," said Mrs. Nickleby. "I think it was in the year eighteen hundred and seventeen; let me see, four and five are nine, and, yes, eighteen hundred and seventeen, that I thought I never should get rid of. I was only cured at last by a remedy that I don't know whether you ever happened to hear of, Mr. Pluck. You have a gallon of water as hot as you can possibly bear it, with a pound of salt, and sixpen'orth of the finest bran, and sit with your head in it for twenty minutes every night before going to bed; at least, I don't mean your head—your feet. It's a most extraordinary cure—a most extraordinary cure. I used it for the first time, I recollect, the day after Christmas-day, and by the middle of April following, the cold was gone. It seems quite a miracle, when you come to think of it, for I had had it every since the beginning of September."

PUBLISHERS' ANNOUNCEMENT.

We have the pleasure of announcing to our readers that we are publishers and proprietors of the JOURNAL which we now present them, and that it is entirely free from any "entangling alliances," whatever, with any college or other organization. It is one of the very few independent medical journals published in this country. The editorial corps is already sufficiently well known. Dr. Baldwin, who was editor of the *Recorder* for five years, and one of the editors of the journal of the State Society last year, will be editor-in-chief, and to aid him we are promised the services of all those who were associated with him in a similar capacity last year.

As publishers and proprietors we shall be more deeply interested in making the JOURNAL prosperous, and to this end we ask the hearty support and co-operation of all our many friends. We invite the attention of all to our list of premiums, and think that few will fail to find something there which they want. For aid in getting up this list, we are under many obligations to Messrs. R. Jones & Son. See advertising page 1.

We request original communications, reports, news items, etc., from all quarters, as we propose to make the JOURNAL as broad and cosmopolitan in character as possible. Fifty reprints will be furnished to authors who so desire, *free of charge*; additional reprints at cost.

Respectfully,

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COMMUNICATIONS.

TREATMENT OF PNEUMONIC FEVER.

BY W. B. HEDGES, M. D., DELAWARE, O.

Read before the Ohio State Medical Society.

Until very recently, pneumonic inflammation was believed to be a purely local affection, and to have its origin from local causes alone, usually from exposure to cold, injuries to the chest, etc. Entertaining this view of the cause and nature of the disease, the early physicians were very naturally led to the adoption of heroic measures calculated, as they believed, to cut short or abort the inflammatory process. In the so-called antiphlogistic treatment of inflammation bloodletting was the chief measure, and one that was supposed to be almost indispensable. In the treatment of pneumonia bloodletting was by many carried to its fullest extent. Cullen and Gregory advised repeated venesections in the same case, and Bouillaud bled his patients daily until the disease was cured, taking at each time from fourteen to sixteen ounces of blood. As the nature and causes of pneumonia are better understood, the inutility of such active treatment becomes more apparent.

The theory so long held by the profession, that the disease is a purely local inflammation of the lungs, arising from local causes, is now believed to be erroneous. The disease is believed to be a constitutional affection, arising from a specific cause, having as one of its chief symptoms infiltration and consolidation of one or more lobes of the lungs, and properly belonging to the class of essential fevers. That pneumonic fever has for its cause something more than mere local irritation of the air passages,

is a fact now very generally admitted by pathologists. It is well known that no one has ever succeeded in producing true croupous pneumonia by any of the agencies that were formerly supposed to be its chief causes. Irritants, of whatever kind, acting upon the air passages, violent contusions and penetrating wounds of the chest, have never been known to produce the peculiar pathological changes in the lungs which characterize croupous pneumonia. "Acute lobar pneumonia is always developed irrespective of any extrinsic agencies acting directly upon the pulmonary organs."*

A series of experiments, carefully conducted by Dr. Heidenhain, under the direction of Dr. Cohnheim, in the Pathological Institute of Breslau, bearing upon the question of the etiology of pneumonia, led him to the conclusion that true croupous pneumonia cannot be excited by irritation of the respiratory passages. If we are to regard as essential features of croupous pneumonia that one lobe of a lung, or part of a lobe (lobar pneumonia), should be affected throughout its whole substance, that there should be coincidently pleurisy, that the trachea and bronchi should remain intact, or at least be only secondarily affected, then he has been unable in any of his experiments to establish that disease. In all cases where any disease at all was produced, the trachea and bronchi were primarily, and the lungs secondarily affected, and the affection of the lung presented in all cases essentially similar characters. There were more or less numerous small foci of disease which corresponded with what, in human pathology, would be called catarrhal pneumonia, or bronchopneumonia. Pleurisy was invariably absent. The general result, therefore, arrived at by Heidenhain is rather in favor of the existence of some specific agent as the cause of pneumonia.†

As long ago as 1866, Dr. Wm. H. Draper, of New York, maintained that pneumonia is something more than a local disease. In a paper read to the New York Academy of Medicine on the treatment of pneumonia, after giving his reasons for believing pneumonia to be a constitutional disease, he said: "These considerations certainly lend support to the theory that pneumonia is something more than a local disease, and is rather an essential fever, having a characteristic lesion like small-pox or scarlet fever."‡ These views have been fully verified by late authors of the highest professional attainments. Juergensen asserts in the most posi-

**Flint Medical Record*, 1876.

†*American Jour. of the Med. Sciences*, Jan. 1878, p. 258.

‡*Bulletin of the N. Y. Academy of Med.*, vol. 11, 1868.

tive manner, that "Croupous pneumonia is a constitutional disease, and is not dependent upon a local cause. The pulmonary inflammation is merely the chief symptom, and the morbid pneumona are not due to the local affection. The hypothesis of a morbid cause is indispensable. Croupous pneumonia cannot be produced by any of the usual causes of inflammation. As in typhoid fever, there must be a specific exciting cause."*

In 1877 Dr. Austin Flint read to the New York State Medical Society a paper on pneumonic fever, in which he points out the "grounds for considering acute pneumonia an essential fever, and not purely a local inflammation," denies the theory so long and so generally held that the disease is a purely local affection, and maintained that the disease is a constitutional affection, and that it properly belongs to the group of essential fevers. He bases his arguments in favor of this proposition upon the evidence furnished by the pathology, etiology, clinical history and treatment of the disease. He says: "It is a fever characterized anatomically by an abundant exudative deposit in the air vesicles of a single lobe, or two, and sometimes three lobes of the lungs, with, in general, circumscribed bronchitis and dry pleurisy. It is a fever which rapidly reaches its maximum of intensity, and has a short career, the duration averaging about eleven days. It proves fatal chiefly in consequence of associated diseases, complications or accidents, and the mode of dying is by asthenia. It is non-communicable, and depends on a cause or causes, specific in character, the nature of which is at present unknown, but having relation to season and climate. It sometimes aborts spontaneously; and it is in some instances arrested by remedies. If not arrested it may be favorably modified, its duration abridged, and the danger to life diminished by treatment addressed, not to the pulmonary affection, but to the fever."†

We have abundant evidence to show that true croupous pneumonia is excited by miasmatic influences, and that the disease thus produced does not differ from ~~any~~ ^{febrile} pneumonia, except, perhaps, in the gravity of its symptoms. The so-called pythogenic or sewer-gas pneumonia, to which the attention of the profession was called a few years ago through the medical journals, may be mentioned in support of this statement. This disease, as it prevailed in the city of Dublin, in 1874, was studied by Drs. Grinshaw and Moore, and was by them pronounced not only in-

*Ziemssen's Cyclopaedia.

†*Medical Record*, 1877.

fectious but also contagious, and the treatment which gave the best results was quinine in five grain doses every third hour and alcoholic stimulants.*

Outbreaks of the same form of the disease are of frequent occurrence in over-crowded and badly ventilated buildings, and the mortality is often very great. Of 98 prisoners attacked in the Kentucky State Prison in 1875, 25 died. Dr. Rodman, who gives a very full report of the outbreak,† satisfied himself that the disease was caused by a polluted atmosphere the result of the filthy habits of the prisoners in the use of their "night buckets." The ordinary treatment by carbonate of ammonia, etc., was useless, but quinine in five grain doses every four hours, with alcoholic stimulants and supporting diet, gave better results.

Pneumonic fever runs a typical course, and, like the essential fevers, is self-limited, and has an intrinsic tendency to end in recovery. In fatal cases death is, as a rule, the result of heart failure. In all uncomplicated cases of pneumonic fever the constant danger which threatens the life of the patient is insufficiency of the heart. The danger from this source is increased by a high temperature and extensive pulmonary exudations; by a high temperature from the increased labor thrown upon the heart, and the direct injury inflicted upon it; by the pulmonary exudation from the increased resistance to pulmonary circulation, which increases the labor of the right heart.

Cardiac exhaustion is often manifest to an alarming degree at the very outset of an attack of this disease, before physical signs show more than a very slight pulmonary lesion, for it must be admitted that there is no uniformity of relation between the constitutional symptoms and the pulmonary affection, or it may appear at any time during the career of the disease; hence this source of danger, the chief and almost only one in pneumonic fever, must never be lost sight of, and measures calculated to depress or weaken the heart should be scrupulously avoided. The treatment of pneumonic fever must accordingly be addressed to the constitutional affection and not to the pulmonary lesion, and the chief therapeutic indications are a high temperature and cardiac exhaustion.

In the treatment of the pyrexia of pneumonic fever, therefore, such measures only should be employed as have the property of diminishing the temperature without injury to the heart. "One of the most important recent improvements in therapeutics is the treatment of fevers by cold

**American Journal of Medical Sciences*, July, 1875, p. 239.

†*American Journal of the Medical Sciences*, Jan., 1876, p. 76.

baths." The external application of cold water in the treatment of typhoid fever is a measure that is now quite generally employed, but its application in the treatment of pneumonic fever is yet quite limited, at least in this country. That cold water applications to the body will promptly and effectively reduce the temperature, no one will deny; but the objections to its use in this disease are so great, it appears to me, as to justify the prediction that it will not be favorably received outside of hospital practice. The belief so long entertained, not only by the public alone but also by physicians themselves, that pneumonia is the result, usually, of exposure or taking cold, has engendered a strong prejudice against the use of cold applications to pneumonic patients, shared alike by all classes of people and to a very considerable degree by physicians, which will strongly operate against the general introduction of this measure however great its merits may be. It has, also, the very serious objection of inconvenient and troublesome application. Cold water may be applied in the treatment of fevers either by the bath, the wet pack or sponging. The bath is highly praised by many, especially by the Germans, as an efficient and perfectly safe means of reducing the temperature in pneumonic fever, and in this country has recently found a few supporters. The efficacy of the antipyretic treatment of pneumonic fever by the cold bath was tested in the Kentucky state prison hospital, in 1875, by Dr. S. E. James. Of 18 cases occurring among the inmates of the prison, in a very malignant type, which were treated by the cold water bath and quinine, three only, or a little less than 17 percent., died. In order to determine the efficacy of the wet sheet in the treatment of pneumonic fever, Dr. Flint carefully selected four cases in Bellevue last winter, which he submitted to this treatment alone. He says: "The treatment is as yet novel in this country. In relating the first two cases at a meeting of a medical society of which I am a member, doubt was expressed by the members as regards a favorable influence produced by the treatment, together with distrust of its propriety and safety. I was not without apprehension, in the first place, in respect of the treatment itself, and in the second place as taking the place of other therapeutical measures, notwithstanding the strong testimony of some German writers in behalf of the efficacy of cold water baths in this disease. Those considerations led to a careful selection of cases." The wet sheet was employed whenever the temperature in the axilla exceeded 103° Fahr. The patient was wrapped in a sheet saturated with water at a temperature of about 80° Fahr. Sprinkling with water of about the same temperature was

repeated every fifteen or twenty minutes. The patient remained in the sheet until the temperature in the mouth fell to 102° , or lower, care being taken to watch the pulse and other symptoms. This author says, in reference to these cases: "They certainly show that in cases like those selected the treatment is not hurtful. More than this, they render probable the inference that the disease was controlled and brought speedily to a favorable termination by the treatment."*

As a therapeutic measure in pneumonic fever, cold is indicated whenever the temperature rises to $102^{\circ}-3^{\circ}$ Fahr. When the bath is to be used the method as practiced by Ziemssen will be found to be the least objectionable. The patient is put into a bath of tepid water, about 98° Fahr., ice or cold water is then added until the temperature of the bath is reduced to 80° , or even 60° , or lower. The duration of the bath is to be governed by the effect produced upon the temperature, being usually from ten minutes to half an hour. The bath is to be repeated at the next rise of temperature, which is not usually more than two or three times a day. While in the bath the patient's pulse should be carefully watched, and stimulants should be administered if indicated. Juergensen strongly insists upon the administration of an alcoholic stimulant before the patient enters the bath, as a prophylaxis against the danger from heart failure. When it is decided to use the pack the patient is simply wrapped in a sheet saturated with water at a temperature of about 98° Fahr. This may be sprinkled with cold water at intervals of ten or fifteen minutes, until the temperature is sufficiently reduced, to be resumed at the next rise of temperature. The use of cold water does not interfere in the least with the use of other remedies.

Quinine, as an antipyretic in pneumonic fever, is undoubtedly the most valuable remedy that we possess. It has the property, when given in sufficiently large doses, of diminishing the temperature without injury to the heart, which renders it peculiarly applicable in the treatment of this disease. Quinine is always indicated by a high temperature, and to be effective it must be given in large doses. "Quinine as an antipyretic should be given to an adult in doses of from one to two scruples. If it prove effective it may be repeated daily, or every other day."† It is in cases of hyperpyrexia that quinine produces its best results, and in doses of from fifteen to thirty grains it will usually cause a decline of temperature amounting to several degrees. The pulse falls with the temper-

**American Medical Weekly*, Jan. 7, 1882.

†Flint, *Clinical Medicine*, p. 67.

ature, but its force is not diminished. The result of an antipyretic dose of quinine will usually last from ten to twelve hours, or even much longer, and the remedy should only be repeated when the temperature rises. No unpleasant effects, aside from slight cinchonism, will follow the seemingly large doses, and this does not appear to be greater than is noticed after smaller and oft repeated doses. Juergensen says: "Quinine in large doses is tolerated in all cases. My experience has gradually led me to give larger and larger doses. It must not be forgotten that the most dangerous enemy to the heart is a high temperature."* In mild cases in which the temperature does not exceed 103° Fahr., five to ten grains given every four or six hours will usually control the fever and prevent exhaustion. Liebermeister says: "Quinine is manifestly the means of saving the lives of patients who already have a very high degree of cardiac weakness, in whom baths are contra-indicated or no longer tolerated."†

Veratrum Viride is by many supposed to possess a specific influence in pneumonic fever. Bartholow says of it: "Much that is extravagant has been written in regard to its curative influence in pneumonia, but we need not be surprised at this when we reflect that our knowledge of the natural history of this disease is only of recent origin. Those who knew nothing of the period of crisis of pneumonia, naturally attributed the defervescence of temperature to the effect of the remedy."‡ *Veratrum* reduces the temperature only at the expense of the muscular powers of the heart, and when we take into consideration the fact that the great danger always threatening the life of a pneumonic patient is insufficiency of the heart, it is difficult to understand how the so-called specific effect of this drug is to be obtained without, in many cases at least, greatly increasing the danger of heart failure.

Aconite, if properly used, is perhaps the most valuable of this class of antipyretics. When given in moderate doses it diminishes the number of pulsations and produces free diaphoresis. It acts directly on the heart by paralysing its muscular fibres, and it is therefore to be used in this disease with the greatest caution. It is only admissible in the most strongly marked sthenic cases, and in those its effects must be most carefully watched. It should be given at the beginning of an attack and when the pulse is full and strong and the skin hot and dry. It is best given in doses of half a drop to one drop of the tincture of the root, every half hour

*Ziemssen's *Cyclopaedia*, vol. 5, p. 177.

†Ziemssen's *Cyclopaedia*, vol., p. 216.

‡*Materia Med. and Therapeutics*, p. 450.

until the febrile symptoms abate. It is well to observe Ringer's caution of using this drug with the thermometer in hand.

Digitalis has recently been advised by some as antipyretic in pneumonic fever, but it is certainly of very questionable utility, except in cases of weak and failing heart, and then only in doses calculated to act as a tonic to that organ. In moderate doses it strengthens the heart and regulates its action and increases arterial tension, and may be given with advantage in the latter stages of the disease in those cases marked by prostration and irregular pulse.

To relieve pain and procure rest opium is always indicated in pneumonic fever. It should be given to the extent of procuring perfect comfort to the patient. Aside from the relief afforded to the patient by opium, it stimulates and steadies the contractile powers of the heart, when that organ begins to flag as shown by an irregular pulse. Dr. Alfred L. Loomis speaks with much confidence of the value of opium in pneumonia marked by cardiac exhaustion. He says: "If then, as I have endeavored to show, deficient or vitiated nerve supply is the great cause of heart insufficiency in pneumonia, and if this insufficiency begins much earlier than is usually recognized by our ordinary methods of examination, for in many instances I have been able to detect it within twenty-four hours from the commencement of the pneumonic attack, occasionally even during the initiatory chill, due, as it seems to me, to the shock which marks the advent of the disease, the question arises, what measures shall we employ to overcome or mitigate the impression made upon the nervous system by the morbid agent which is operating to produce the pneumonia? The experience of the last eighteen months leads me to state with some positiveness that in opium we have such an agent. My rule for the past year has been to bring my patient under the full influence of the drug at the outset of pneumonia, and to hold him in a condition of comparative comfort until the pneumonic infiltration is complete (usually for the first four days of the disease). After this period the greatest care must be exercised in its use, for a new danger threatens, namely, paralysis of the bronchi, and consequent accumulation of secretion in the bronchial tubes, which will greatly increase the difficulties of respiration."* The tendency to exhaustion from failure of the heart is undoubtedly greater in pneumonic fever than in any other of the essential fevers, hence the necessity of prompt and efficient supporting meas-

**Medical Record*, June 25, 1881.

ures. These include alcoholic stimulants and nutritious alimentation. No absolute rules can be laid down for the use of either, and especially is this true with regard to the use of alcohol. Many cases of this disease are so mild as to require little more than palliative treatment; others, again, are from the very outset marked by extreme and dangerous exhaustion. It is the latter class of cases which require prompt and energetic stimulation by full and efficient doses of alcohol, given as often as indicated by the pulse, for the pulse must be our guide in the use of alcohol. It is always indicated when there is the slightest tendency to insufficiency of the heart, as shown by a rapid, irregular and compressible pulse. Cases in which the exhaustion is already extreme, with a feeble and irregular pulse, delirium and profuse perspiration, require the most prompt and efficient stimulation; such cases will surely die unless the cardiac exhaustion can be overcome, and alcohol is the only remedy that can be relied upon in such emergencies.

In the supporting treatment of this disease, the importance of a full allowance of nutritious alimentation cannot be overestimated. Food in a concentrated form should be allowed the pneumonic patient from the commencement of the attack. Milk and eggs are to be preferred as a diet for fever patients. The milk should be fresh, and given in suitable quantities and at regular intervals. Eggs should be administered raw, whipped up with milk and seasoned to suit the taste, or given in the form of egg-nog. I do not place any reliance in the time-honored beef tea and beef essence as articles of alimentation in fevers. They are difficult of digestion and at the best are very inferior to milk and eggs.

“To conclude: in the milder cases there is no positive necessity for any treatment except a simple regulation of the diet. But the prudent physician will even here usually prefer active interference to passive expectation. In severe pneumonia very much may be accomplished by treatment, if it be carried out in strict accordance with the principle that in this infectious disease it is the heart whose activity must be maintained against the evils which directly threaten it.”*

*Ziemssen's *Cyclopaedia*, vol. 5, p. 181.

ON DIGESTION.

BY A. M. BLEILE, M. D., COLUMBUS, OHIO.

Lecturer on Physiology, Starling Medical College.

Read before the Ohio State Medical Society.

In the following paper I give a brief resume of the teaching of to-day on digestion, together with a few facts brought out by my own experiments, which were, however, incidental to another question in physiology on which I am still engaged; I will not give the details and minutiae of my experiments to the Society, as that would probably only prove wearisome to the most of us to-day, but shall simply give the results found.

Saliva. Mixed saliva is the product of the parotid, sub-maxillary and sub-lingual glands, the portion furnished by the smaller glands scattered through the buccal cavity being inconsiderable in amount and action. As special constituents we find a trace only of albumen, mucus in quantities varying widely under different circumstances, sulpho-cyanide of potassium, the significance of which is not known, salivary corpuscles with the enclosed granules in rapid motion, a ferment called *Ptyalin*, and, finally, a substance not further known, which may have toxic effects on animals.

Secretion has been most studied in the submaxillary (dog, specially). This gland, on irritation of the chorda tympani, gives a copious watery secretion, its arteries and veins dilate, and the blood issuing from the latter is bright red. That secretion is the effect of changes in the gland cells, and is not derived from the increased flow of blood alone, is shown by:

1. Secretion goes on against a pressure in the gland duct higher than that of the blood.
2. Its temperature is above that of the blood flowing through the gland.
3. Secretion goes on after cessation of the blood flow, and, contrariwise, atropia arrests secretion, although the blood vessels dilate just as before on irritation of the chorda.
4. Under the microscope, changes in the cells of the acting and the rested gland can be directly noticed; in the one case they are smaller and filled with granular matter, in the other larger and almost homogeneous, excepting a small granular mass near the border, and from this mass the cell again becomes granular. The secretion obtained from the submaxillary on irritation of the sympathetic, is quite viscid and spare; here all blood vessels are contracted.

The secretion of the parotid is clear and limpid, and contains no mucus. Irritation of the cranial nerve (auriculo temporal—trigem.) produces increased secretion, but as yet no effect has been observed from irritation

of the sympathetic alone. When both nerves are stimulated, there is an increase in the organic matter of the secretion.

Sub-lingual saliva, little investigated, is more viscid, and richer in solids than that of the other glands.

One of the functions of saliva is to act as a lubricant. It further has the power of changing starch into dextrin and sugar, possibly all of it into sugar if sufficient time is given. Two dextrines are produced, the erythro and the achroo dextrin; the first giving a red color with iodine, the second no reaction. It is pretty definitely settled that the sugar produced is not grape sugar, though agreeing with it in many of its qualitative reactions. The name Ptyalose has been proposed for this product.

Even very dilute acids (.04 per cent. HCl, in my own experiments) destroy the ferments. From this it would seem that the role taken by the saliva in the digestion of starchy matters depends on how long the food remains in the mouth, for its action must cease very soon after its entrance into the acid stomach. It also shows how useless it is to give *ptyalin* in preparations said to contain all the ferments in the alimentary canal.

In grave diabetes, the saliva may take on an acid reaction.

Gastric juice is the product of the epithelial cells lining the mucous membrane, and of two sets of glands—the one situated chiefly at the pylorus and the cardia, the other—the peptic glands—distributed far more widely and closely throughout the stomach. Gastric juice ordinarily contains little or no mucus, the ordinary salts, from .2—.5 per cent. HCl, its specific ferments, pepsin, rennet-ferment, lactic acid ferment, and, in many cases, free lactic acid as a product of fermentation.

Studies made with artificial gastric juice, i. e., glycerine or water infusions of the mucous membrane and HCl, are quite satisfactory and in most instances take the place of juice obtained through a gastric fistula.

In the peptic glands we have two kinds of cells; large, ovoid border cells, formerly called peptic cells, and central, smaller cells, the chief cells. Before a meal these latter are pale and finely granular; early in digestion they are larger, turbid, and coarsely granular; later, still more turbid and granular. The same changes are observed in the cells of the mucous glands. These cells in both glands furnish not the pepsin directly, but pepsinogen, from which the pepsin is formed during secretion. The peptic glands furnish the acid, and probably through the cells formerly called peptic cells. In fever, the secretion of acid is lessened or quite suppressed, whereas the pepsin is not notably affected; an explanation, possibly, of the good effects of the administration of the mineral acids in typhoid notably. Local irritation

of the stomach produces a secretion, but only at the spot irritated, and secretion goes on even after division of the pneumogastrics; yet other facts show that secretion is, in part, at least, controlled by a reflex nervous mechanism, the paths of which remain to be made out.

In gastric digestion the albuminoids chiefly are affected, being ultimately changed by the pepsin into a substance called peptone, differing from them, 1, in not being precipitated by boiling or acids; 2, nor by K_4FeCy_6 and acetic acid; 3, nor by neutralization of its acid or alkaline solution, and, 4, in being highly diffusible. Much discussion has been had as to compounds intermediate between albumen and peptone and the matter is not yet fully cleared up. Peptone is to the albuminoids chemically as hydrates are to the anhydrides. When injected into the blood it has the power of preventing blood coagulation, a fact to be borne in mind in connection with the intra-venous injections of this substance lately recommended after exhausting hemorrhages. The rennet ferment coagulates milk, even in alkaline solutions, and the lactic acid ferment, whose existence is, as yet, not entirely beyond a doubt, converts sugar into lactic acid.

Further Action in the Stomach. Starch is partially converted into soluble starch and erythro-dextrin, cartilage is dissolved and partially digested, gluten and connective tissue dissolved, the gelatine losing its peculiar property, and fats are liquified and partially split up into fatty acids and glycerine. I have found that cane sugar is speedily converted into grape, or at least, a reducing sugar, both by artificial and natural gastric juice. This change is probably brought about by the acid only, for I find that HCl, even in great dilution, will convert cane sugar promptly when held at the body temperature. So little as .005 per cent. acts decidedly in 15 minutes, and even .003 per cent. will act in 2-4 hours.

In fevers, as already mentioned, pepsin continues to be formed, but little or no acid, and fermentation and gas eructation can take place in the stomach only when there is neutral or alkaline reaction. Administration of alkalies by neutralizing the acid forming, which would finally check fermentation, will therefore only make matters worse in the end. Small doses of salicylic acid and then HCl, to increase peptic action, would seem to be indicated in such a condition. The administration of pepsin can do little good in dyspeptic conditions, unless HCl, or a substance like bismuth, which possibly acts as a local stimulus, accompany it.

The Intestinal Juice. This also has three sources: 1. The columnar epithelium, lining the part. 2. The mucous, or Brunner's glands. 3. The follicles of Lieberkuhn. The juice is alkaline, contains mucus, coagulable

albumen and ferments. No method has yet been devised better than Thiry's for obtaining larger quantities of this juice in a normal state. Division of the nerves of the part gives rise to a copious watery flow.

As to the special action of the intestinal juice, there is still much doubt, some observers crediting it with all the powers of the other juices, others giving it only a power over starch and then not more than is found in infusions of other tissues. Albumen and starch, placed in isolated parts of intestine, were slowly digested, but here simple putrefaction may have played an important part, all the more readily the bile being wanting. I worked with glycerine and water infusions of the dog's intestine, and found them to act constantly on starch in neutral and slightly alkaline media; greater alkalinity and acidity, as 2 per cent. HCl, destroyed this power. On fibrin I found no action whatever, either in neutral, alkaline or acid fluids. Cane sugar was always promptly converted in a neutral or feebly alkaline solution. Greater alkalinity checks this, and acids, as I have already stated, invert cane sugar of themselves at 40°C.

In the normal state the amount of secretion of the intestine must be very small. In a dog with an intestinal fistula, I never saw fluid escaping unless after feeding, and then with the food only. The large intestine has no digestive action, *per se*, but digestive changes started higher up may to some extent continue here.

Pancreatic Juice. This is obtained from a fistula, or infusions of the gland. The pancreas is, histologically, like the salivary gland, and they have one ferment in common.

This juice contains a larger quantity of proteids than the other fluids, and changes its composition with the rate of secretion. It contains albumen, leucin, tyrosin, fats, soaps, sodium carbonate and three ferments. That there is a nervous regulation for this secretion is shown by several facts. The flow rises almost immediately after the ingestion of food, falls about the second hour, to rise again, but not so high, about the sixth hour. Irritation of the medulla oblongata increases the flow. Nausea or vomiting, and also irritation of the central end of the cut vagus, arrest it. Afferent impulses go up by the vagus, but influences going to the gland follow a path as yet unknown.

The pancreatic cells, before feeding, show a large granular inner zone, the secreting material, and a smaller outer clear zone; which position becomes reversed during digestion to such an extent that the inner granular zone may almost disappear. The cells also shrink, the increase and decrease of the two zones not being equal. The nucleus, irregular and dis-

torted at first, becomes sharp, round, with a plainly visible nucleolus.

Pancreatic juice acts on starch more powerfully than saliva, but with the same end products. The second ferment, trypsin, is not contained as such in the gland, but formed from its zymogen and oxygen during secretion. It converts albuminoids into peptone, like pepsin, but along with it are formed two crystalline bodies, leucin and tyrosin, in quantities varying with the amount of albuminoid matters introduced, a relatively much larger quantity arising after a larger ingestion of albuminoid matter, than when less is taken in. The third ferment splits fats into glycerine and fatty acids. These latter facilitate the production of emulsions—which are, however, readily formed in albuminoid fluids—by forming soaps with the alkalis present. Soaps are probably necessary, and are formed in small quantities only and do not enter the blood as such; for I have shown that their introduction, in small quantities even, directly into the blood causes an intense, though transient, hematuria. Pancreatic juice acts only in neutral or alkaline fluids: additions of acid (HCl to .5 per cent., or Na_2CO_3 to .3 per cent.) destroy it. Out of the body this juice and foodstuffs rapidly undergo putrefaction. In the intestine it is hindered, but not entirely prevented, by the bile, and its products soon appear, some of them being those produced by digestion only; of the others I will only mention indol, and, in man, skatol, which give feces their characteristic odor and gases.

Trypsin, or Pancreatic Ferment, is itself digested by the gastric juice; another argument against preparations containing all the ferments of the alimentary canal.

The Bile. This takes a secondary role only in digestion, and I will not consider it in detail. Through its alkalinity and solvent action on soaps, it may assist in fat digestion, and the intestine may be more readily permeable from its presence. The bad effects from loss of bile by fistulæ are likely only due to loss of certain substances which are re-absorbed from the bile, and not to the want of the assistance of this fluid in digestion.

RETINITIS ALBUMINURICA.

BY S. C. AYRES, M. D., CINCINNATI.

Read before the Ohio State Medical Society.

Diseases of the kidneys form an interesting and deservedly important group. From the earliest history of medicine they have excited unusual attention, and particularly since the pathological changes have been studied by the aid of the microscope. Chemistry, also, has come to our aid to explain many changes which take place in the secretion of these organs, and has thrown a flood of light on a subject which was once enshrouded in darkness. More recently the ophthalmoscope has opened a new field of investigation, and we now detect retinal alterations even before the presence of Bright's disease is known to the patient.

I need not describe the symptoms of this much dreaded disease; they are familiar to you all. You have all probably watched these cases, and marked with the test tube the varying amounts of albumen as symptoms were favorable or unfavorable. You have seen some of these cases recover under treatment, and others gradually progress in spite of your best endeavors to check the malady. From the fact that some of these cases first fall into the hands of the oculist, in consequence of the retinal complication, it would seem that the symptoms of renal disease must be masked by symptoms attributable to other organs. It is well known that vomiting, dyspepsia, diarrhea, anorexia and anemia are associated with Bright's disease, and yet they may all fail to lead the physician to the true source of the trouble, unless he resorts to the aid of the test tube and the microscope. Even dropsy, a symptom upon which we place so much reliance, may be so insignificant as not to excite much attention until the disease has nearly run its course. I do not propose to discuss the question of Bright's disease, nor to lay down any general line of treatment, for you all have your own experiences, but I wish to call your attention to the manifestations of this disease which are visible with the ophthalmoscope.

It occasionally happens, and I have seen a few such cases, that the failure of vision is the first symptom which makes the patient aware that he is suffering with disease of the kidney. Previous symptoms have been either misconstrued or overlooked, and when he finds his vision failing he flies to the specialist for advice. I do not know in what proportion retinitis albuminurica is associated with Bright's disease. According to

some statistics it occurs in from nine to twenty per cent., and according to others in thirty-three per cent.

Dr. Earles (*Birmingham Medical Review*, 1880), in a report of 100 cases of kidney disease, is thus summarized by Dr. Noyes, in his recent work on disease of the eyes, which I quote: "Out of 100 cases 94 had albumen when examined; almost all were inspected but once. In 28, there were retinal lesions, and in 3 there were lesions of the optic nerve. Of the 31, about one-third were unaware of any visual defect. In 12 of the 28, both eyes were affected; in 16 but one eye was concerned—a result unlike what previous observers have recorded, probably because the cases studied by others have been those in which conscious visual defect occurred."

Galezowski reports eye lesions in albuminuria at thirty-three per cent.; Lecorche at twenty-one per cent., and Lebert at twenty per cent. Flint says that he has seen six or eight cases of amaurosis in about a hundred cases of Bright's disease. Voelckers reports that out of 30 cases two were incident to pregnancy; all the rest were in individuals who were suffering from atrophy of the kidneys.

I am indebted to Dr. E. Carson, *interne* of the Cincinnati Hospital, for the following statistics on the subject for the years 1877, '78 and '79. The records show that there were during that period 104 cases of albuminuria. Typical retinitis occurred nine times, or in 8.6 per cent. There was one case of blurring of the optic discs, which was probably the initial stage of retinitis. As no subsequent ophthalmoscopic examination is recorded, we cannot state what retinal changes may have taken place. The patient died of Bright's disease, and I deem it proper to include him in the above cases of retinitis. This will make the whole number 10, or 9.6 per cent. Ophthalmoscopic examinations are recorded in three cases, where no retinal changes were seen. This would leave 91 cases where the eyes were either not inspected, or where no record of such inspection was made. I am disposed to think that the former is true, and that the eyes were never examined. It is quite likely that retinal complications may have occurred in several of them. The final result of these cases of retinitis is as follows: Of the whole number (ten) five died; three were reported as improved, two as unimproved, when discharged from the hospital.

It may interest you to know that phthisis occurred in eight cases, or 7.6 per cent., pneumonia in 3.8 per cent., and aortic stenosis in two cases. In one case the typical retinitis was associated with a tumor of

the brain. Of the whole number (104) reported for these three years, 33, or 31 per cent. died; 26 per cent. were reported as unimproved, 48 per cent. as improved, and none as cured.

I am disposed to think that retinal complications occur in only a small proportion of the total number of cases of albuminuria, and these principally in the small granular or contracting kidney.

The changes noticeable in the fundus oculi are so characteristic and striking that when once seen they can be easily recognized again. It has been confidently stated by some that this disease could always be identified with the ophthalmoscope when any ocular complication occurred. While this statement is true for the great majority of cases, it is not absolutely true for all. There are cases of neuro-retinitis associated with brain tumor, which very closely resemble in all particulars the ophthalmoscopic picture which one sees in albuminuria. The other associated symptoms, and the absence of albumen, will here decide the question as to its cerebral or nephritic origin.

When the fundus oculi is inspected in the early stages of nephritic retinal inflammation a blurring of the optic disk is noticed, with obscuration of the blood vessels, particularly of the arteries. The retina presents an edematous or opaque appearance, and seems to have been pushed forward toward the cornea. The eye in such cases appears hypermetropic, from the change in the relative position of the retina. Here and there are circular or irregularly shaped white splotches on the retina, due to fatty degeneration. They are most numerous around the macula lutea, and arise from changes in the cellular and connective tissue elements of the retina, especially the external granular layer. There are also white lines in the region of the macula lutea, arranged in a stellate form, which constitute the most striking feature of the ophthalmoscopic picture. Taking the yellow spot as a center, these lines diverge from it, but only form an arc of a circle. They are on the temporal side of the optic disk, and appear as bright and shining as opaque nerve fibre. Hemorrhages, more or less abundant, are scattered over the central portion of the retina, or directly in the vicinity of the macula. After the disease has run its course, it often leaves a central scotoma and the fundus marked by a patch of choroidal atrophy, fringed with pigment. At other times the retinal manifestations disappear entirely, leaving no trace behind. This is particularly the case when they occur during pregnancy. It is surprising to note that in some cases of marked retinitis there is very little or no impairment of vision. It seems paradoxical to make such a statement, but it is nevertheless true.

The probable explanation is that the conducting nerve fibres are not interfered with, and that the macula lutea is intact. I well remember an instance where vision was almost perfect, and yet the patient had a retinitis in both eyes which seemed sufficient to quite destroy vision.

One of the peculiar symptoms is the loss of color sense, while the field of vision remains intact. Dr. Holmes, Chicago, reported in the *Archives of Ophthalmology*, a very interesting case of retinitis albuminurica occurring during pregnancy. The patient was totally blind three weeks, and absolutely color-blind three months. Perception of black and white first returned. "At the end of three months blue tints began to appear, then yellow, brown and red, and finally green." It was only after five years that she had power to distinguish different shades of green. From being absolutely blind she recovered excellent vision and could read Jaeger No. 1.

It is only recently that I had an opportunity of seeing two cases of albuminuric retinitis, both ending fatally. One, a journalist of this city, had for years suffered from the malady, and had been judiciously treated by skillful men. His vision began to fail in both eyes almost simultaneously, and presented the characteristic ophthalmoscopic changes. Swelling of the optic disk, cloudiness of the retina, exudations in the region of the macula, and retinal hemorrhage, were visible in both eyes. The changes in the retina seemed to be the last act of the drama which was to close his career. As his vision was veiled, the curtain slowly descended and in a few weeks dropped between him and all things earthly.

Another one was a member of this Society (Dr. Brown, of Dennison,) doubtless known to many of you. He was a hard worker, attending to a laborious practice and taking care of every one but himself. The disease insidiously gained on him, but still he worked on, never resting until his vision began to fail. The ophthalmoscope showed the characteristic changes, and the test tube proved the urine highly charged with albumen. He seemed to suffer very much with his heart, and had difficulty in walking or going up stairs. His skin was dry and parchment-like, and his body somewhat emaciated, which latter condition had developed rapidly. He had an unquenchable thirst, and suffered from insomnia. In scarcely more than two weeks from the time the ocular symptoms had developed themselves, he died.

Albuminuria may occur in the forms of kidney disease described (Flint) as large kidney, large waxy kidney, and the small granular kidney. It

also is associated with typhoid fever and scarlatina, and with pregnancy as has been mentioned.

Along with Bright's disease is often noticed hypertrophy and dilatation of the left ventricle. Flint says that out of twenty-six fatal cases, in eleven there was more or less enlargement of the heart without valvular lesion.

It is not supposed that you are all sufficiently skilled in the use of the ophthalmoscope to diagnose Bright's retinitis, (I heartily wish you were) but it is in your power to determine the presence or absence of albumen in cases of amblyopia. May I presume to ask you to pay some special attention to these cases, to take notes of them, and to let the profession have the benefit of them. It is difficult for one person to furnish large statistics on any subject if he depends on his personal observations. It requires the concurrent observations of a large number of persons, extending over a broad area. Now in our State Society we have, say, in round numbers, six hundred members. If we wanted to determine how often retinitis was associated with Bright's disease, and I could get a report from each member of five cases only, it would give us a total of three thousand cases. It would be both interesting and valuable to determine this point, and with your assistance I will endeavor to do so. If this is not an association for mutual improvement, and for the collection and dissemination of valuable information, what is it? You could in a short time collect your cases, send them to me, and furnish me with statistics which would be of practical value to the profession, and would make the work of our Society attract great attention. You could, at the same time, mention cases of amblyopia occurring during pregnancy, and after scarlatina and typhoid fever. I take it that this is the legitimate work of our Society, and that this is the way to work together. The time is past when one man writes a work on practice or surgery. It is done by a great many hands, and is much better done than by one. Now if you can furnish the cases of Bright's disease occurring in your practice, and they can be collated, and deductions made therefrom, you will be helping to determine facts, and these are what we are after. Will this appeal meet with a response from the members?

SELECTIONS.

SURGERY.

DEATH FROM USE OF DAVY'S ARTERY COMPRESSOR.—This instrument, it will be remembered, was devised by Mr. Davy to compress the common iliac artery in amputating at the hip-joint. It is a well-turned straight wooden rod, about the circumference of the little finger, and two feet in length. It is used by passing about seven inches of it (in an adult) up the rectum and toward the side to be operated upon; on then raising the handle, or part outside the anus, the upper end compresses the common iliac artery just in the depression between the sacrum and ilio-pectineal line. Amputation at the hip-joint, or high up the thigh, can be performed without any arterial hemorrhage, and the vessels are controlled with remarkable ease. It has been used many times successfully. A correspondent of the Philadelphia *Medical News*, however, reports two fatal cases, where death could be traced directly to the use of the instrument. No particulars of the first case have been made public, but the second happened in the hands of Mr. Davy himself. Nothing untoward was noticed at the time of the operation, which seemed to be entirely successful. After twenty-four hours, however, peritonitis set in, and the patient sank rapidly and died. At the autopsy a perforation of the rectum was detected just seven inches from the anus. The rectum elsewhere appeared healthy; there was no sign of ulceration about the perforation, and there can be no reasonable doubt but that it was produced by the end of the lever. It was the right common iliac artery that was compressed. Mr. Davy had no suspicion at the time of the operation that anything had gone wrong. The only mishap with the lever is the impossibility of passing it sufficiently high up the rectum. This once happened to the reporter, who, after an oil injection, and using all the force he considered safe, failed to pass the lever more than four inches. After the death of the patient there was found a sharp bend of the rectum, which rendered it impossible to pass the lever, even on the post-mortem table. The reporter concludes that for compressing the *right* common iliac artery it is *dangerous to life*, and that there are other means of controlling the vessels, which in skillful hands are not unsuccessful. Whether it may be safely used in all cases for compression of the *left* artery, is another question.

A PAINFUL AFFECTION OF THE WRIST.—In the July number of the *New York Medical Journal*, Dr. Edward H. Bradford, Surgeon to Out-Patients, Boston City Hospital, relates three cases of a painful affection of the wrist, the features of which were: pain referred to or most severe at the middle of the carpus; slight swelling; an absence of constitutional disturbance, with no interference, or but partial interference, with motion of the articulation between the carpus and the radius and ulna. The symptoms were relieved by fixation, and recovery took place finally after a period of rest. Judging from analogy, Dr. Bradford remarks, it seems probable that the cases here reported were similar to a degree to a synovitis of the medio-tarsal joint, described by Gosselin under the term *tarsalgia adolescentium*: differing somewhat in their course from the fact that the wrist, a part easily immobilized from the first, and not the tarsus, was affected. Leaving out of account the smaller synovial membranes of the carpus—i. e., those between the pisiform bone and the cuneiform, the trapezium and the metacarpal bone of the thumb, the ulna and the fibro-cartilage at the joint—there are two large synovial sacs, viz., between the main carpal bones and the radius and cartilage covering the ulna, and that between the main bones of the carpus, of which the os magnum is the larger and central bone. From the symptoms in the cases reported, the author thinks that the inflammation was one affecting this latter synovial sac, and limited to this alone, and that they may therefore be termed cases of synovitis of the carpus.

DIGITAL EXPLORATION OF THE BLADDER THROUGH INCISION OF THE URETHRA FROM THE PERINEUM.—At a meeting of the London Royal Medical and Chirurgical Society, held April 11, 1882, Sir Henry Thompson reported a case in which he had successfully removed a tumor of the bladder (in a man) through a perineal section of the urethra. The patient had been operated on some time previously for stone (by lithotripsy) but without complete relief to his symptoms; subsequently some phosphatic deposit was removed by the lithotrite, at this time he seized what at first felt like a calculus, and practically crushed it under pressure, but it was evidently fixed, giving the impression of partially impacted stone. As little benefit followed this operation it was decided to open the bladder. This was done by perineal section, and on introducing his finger into the bladder, pressure being made from above the pubes, Sir Henry recognized a tumor about the size of a chestnut growing from the opposite wall, coated with phosphatic matter. The mass was easily twisted off with a

pair of forceps. Very little bleeding followed. The patient speedily recovered and had no return of the bladder symptoms subsequent to the operation. Regarding this and other cases, Sir Henry advised that in certain cases of hematuria which was clearly vesical and was not explicable except by the hypothesis of impacted calculus or vesical tumor, an incision of the membranous portion of the urethra from the perineum, for the purpose of exploring the bladder, should be made. In a paper in the *Lancet* of May 7, 1882, Sir Henry remarks that it is only during the last few years that he has gradually realized the fact that it is possible in not a few cases, to explore through a small perineal incision the whole, or nearly the whole, of the internal surface of the bladder with the index-finger—a necessary condition, of course, is that the bladder should be empty, and that firm pressure should be made with the right hand above the pubes. The method of operating the author describes as follows: The central incision should always be adopted, and a median grooved staff, and a long, straight narrow-bladed knife, with the back blunt to the point, should be used. Having placed the left index-finger in the rectum, the knife may be introduced edge upward, about three-quarters of an inch above the anus, with or without a small preliminary incision in the skin, until the point reaches the staff about the apex of the prostate gland, where it divides the urethra for half an inch or so and is then drawn out, cutting a little upward in the act, but so as to avoid any material division of the bulb. The left index-finger is now removed from the rectum, and following the groove of the staff, slowly passes through the neck of the bladder as the staff is withdrawn when exploration is made. This operation is often of benefit in old cases of cystitis, and, as well as satisfying the surgeon as to the exact condition of the bladder, often relieves symptoms where no lesion can be made out.—*Canada Med. and Surg. Jour.*

A NEW METHOD OF DETECTING SMALL STONES IN THE BLADDER.—Dr. S. Cuthbertson Duncan has used for about three years the following method of detecting stone when small or in fragments. He takes a nickle-plated sound, such as is used for that purpose, and holds it over the flame of an ordinary lamp or candle until the point is covered with a thin black film. After it has become quite cool, it is dipped in a solution of colloidion and allowed to dry. He then oils it with castor oil, and introduces it a short distance in the urethra and withdraws it to see if it be injured. If not he proceeds to explore the floor of the bladder with a sweeping lateral movement. If there be a stone or any fragments left after lithotrixy,

its black covering will be removed in patches, and the bright metal will show through. The author thinks this more delicate than Napier's indicator, the point of which is made of lead, blackened by chemical agents; and this very method does not impair the conducting power of the sound in any degree. A short beaked solid steel sound is preferred, with a round handle, which has a flat disk about two inches from the end, at right angles to the curve of the beak, to serve as a guide for the direction of the point. The round handle allows it to be rotated between the index-finger and the thumb, the most sensitive part of the hand—two things necessary for rapid and delicate manipulation.—*British Medical Journal*.

SYMPATHETIC OPHTHALMIA.—Dr. S. C. Ayres reports three peculiar cases in the *Archives of Ophthalm.* In the first, the affection came on about a year after the enucleation of the originally diseased eye. Examination showing that the stump of the optic nerve was painful, a resection was performed, when all sympathetic trouble disappeared and seven years later had not returned.

In both the other cases, *persistent poulticing* was followed by relief of pain and ultimate recovery.

OPHTHALMIC APHORISMS.—Dr. J. J. Chisolm, of Baltimore, gives the following valuable aphorisms in a report presented to the Maryland State Medical Society at its last session:

1ST APHORISM.—*Do not blister.* In forty-nine applications out of fifty, as I find it used by physicians at large, it is an additional and useless torture to the eye disease from which the patient is already suffering.

2d APHORISM.—*Do not use nitrate of silver.* As constantly prescribed by general practitioners, it is not beneficial in one case out of one hundred, and therefore is a very painful infliction to the ninety-nine who would have been so very much better off without it.

3d APHORISM.—*Do not prescribe sugar of lead.* In every case zinc, tannin or alum is better, and then there is no fear of having insoluble deposits incorporating themselves with the exposed surface of corneal ulcers.

4th APHORISM.—*Always use weak solutions of the mineral and vegetable astringents* in the treatment of eye inflammations which attack the mucous surfaces, and restrict their application to conjunctival diseases exclusively. One grain of alum, sulphate or chloride of zinc, sulphate of copper or nitrate of silver, in an ounce of water, will in the majority of cases of con-

junctival diseases, do much more good and give much less uneasiness than the very painful five and ten grain solutions which are so often injuriously prescribed by physicians.

5th APHORISM.—*Solution of the sulphate of atropia*, from one to four grains to the ounce of rose water, is an essential eye-drop in the treatment of acute iritis, to break up newly formed adhesions. One drop of the atropia solution in an inflamed eye is a most valuable means of establishing the diagnosis whether iritic complications exist or not, and should be used in most cases of eye inflammation to find out whether there are any adhesions of the pupil to the lens.

6th APHORISM.—*Eserine in solution of one grain to the ounce of water* is the remedy for purely corneal lesions.

7th APHORISM.—When physicians are in doubt as to the character of an eye disease, they should seek a consultation from specialists who are more familiar with eye diseases than general practitioners can possibly be. Such timely aid often saves the patient a lifetime of trouble.

If physicians would commit to memory and keep at their finger ends, and ready for use, these simple aphorisms, the amount of mental and bodily suffering which they will prevent in their eye patients is beyond calculation. While all good rules have necessarily many exceptions, they may safely follow their simple guidance.

DACRYOLITHS.—Concretions formed by the deposit of the saline elements of the tears, are but rarely observed. Prof. H. G. Cornwell, of Columbus, O., (*American Journal of the Medical Sciences*, for July, 1885,) reports the case of a man aged forty-six, who complained of an interference with the escape of the tears from the left eye, which had annoyed him for ten years. An examination revealed lachrymal conjunctivitis, the lachrymal punctum slightly everted, its orifice of normal size and the walls of the canal somewhat thickened. No accumulation of tears in, or any evidence of inflammation of the lachrymal sac. Suspecting a stricture of the canaliculus this passage was slit up by means of a delicate pair of scissors, one blade of the instrument passing readily through the canal without obstruction. On the following day on attempting to separate the edges of the incision to prevent their union, by means of Bowman's probe held vertically, the instrument struck a gritty substance which proved to be one of four dacryoliths which were arranged bead-like along the floor of the canal. The canal itself, after their removal, was found to be much enlarged as a result of this calcareous deposit.

SCIATICA.—Mr. Jonathan Hutchinson, in a clinical lecture on “sciatica,” sums up his conclusions as follows: In nineteen cases out of twenty in which the diagnosis of “sciatica” is suggested there is no affection of the sciatic nerve whatever. They are simply cases of arthritic disease of the hip in one or other of its various forms—acute gout, chronic gout, rheumatic gout, subacute rheumatism, or chronic senile rheumatism. Both by the public and the profession these cases are constantly called “sciatica.” Our workhouse infirmaries are full of chronic cases under that name, and I speak advisedly when I say I feel sure that they are almost all examples of *morbus coxæ senilis*. Of the cases of “sciatica” which are not hip-joint rheumatism, some are probably affections of the fascia or periosteum near to the hip; a minority are possibly affections of the sciatic nerve itself. In these latter it is the sheath of the nerve which becomes painful. The pain may be darting, or may radiate, but it does not pass down the nerve-tubules or in any way make the patient conscious of their course. The diagnosis of true sciatica is to be based upon the discovery of tenderness restricted to the trunk of the nerve, and involving a considerable part of its course. Examples of this are decidedly rare, and their recognition without risk of error is a matter of great difficulty.—*Medical Times and Gazette*.

THE REMOVAL OF NASAL POLYPI.—Dr. Morrell Mackenzie discusses the various operative methods of removing nasal polypi and states that the mode of treatment he generally adopts is to remove the polypi with his punch-forceps and then to apply the electric cautery to the base of the growths. This method will generally succeed in effecting a rapid cure, but when recurrence repeatedly takes place, if the growth springs from one of the turbinated bones, he removes a portion of the bone from which the polypus originates by means of a special instrument which he has devised for the purpose. It consists of fine hollow forceps having toothed edges on one side and smooth edges on the other, whilst between the two a sharp cutting blade can be rammed down. The portion of the turbinated bone required to be removed is seized by the forceps, the smooth blade being on the outer side. The knife is then pushed home and the portion of the bone easily removed. He wishes it to be understood, however, that though he considers the removal of a portion of one of the turbinated bones perfectly harmless, he regards it as an operation rarely required.—*Arch. of Laryngology, Phila. News*.

OBSTETRICS.

TREATMENT OF THE PLACENTA AFTER ABORTION.—Dr. Stanley P. Warren, of Portland, presented a practical paper on this subject at the late meeting of the Maine Medical Association, in which he classified abortions under four heads, advocating primary extraction of the placenta without leaving the result to nature, observing, of course, all proper precautions with reference to shock and hemorrhage.

Class 1.—Sudden flooding, cervix open, severe shock, and it is unknown whether the placenta has been expelled or not.

Class 2.—Moderate hemorrhage; the fetus has recently been expelled; the cervix open and the placenta within reach; general condition good.

Class 3.—The fetus has been expelled for some days; the secundines are retained; the lochiæ are fetid and some form of septic inflammation is present in the pelvic cavity.

Class 4.—There has been more or less flooding; fetus has been expelled; cervix is closed, and the placenta cannot be reached by the finger; general condition good.

Cases were cited illustrating each of these divisions, and facts presented as to the subsequent condition and labors of these patients.

For the first class the Doctor recommended procedures which should relieve shock and check hemorrhage, and as soon as reaction was well established, the contents of the uterus, if any, should be removed.

In the second class there seems to be no question as to the propriety of immediately evacuating the uterus, if the placenta is free and can be removed *without preliminary dilatation of the cervix*. It is to be regarded as simply a foreign body. There is less danger of injury to the tissues with the finger than with the curette; it also has the advantage of the sense of touch. The curette, on the other hand, causes less pain and may be used with or without the speculum; has not found the ovum forceps as safe as the curette, still less than the finger, and ought to be used very cautiously in the uterine cavity.

In the third class, where we have present or impending some metritis, no good reason obtains why the uterus should not be, within 24 hours, relieved of its contents and thoroughly cleaned; the cervix is usually patent and requires no dilation; a dull curette, followed by intra-uterine, not carbolized, injections, will accomplish every desired object in the way of removal. The quicker the focus of infection is taken away, the less is reparative action delayed and septicemia to be expected.

In dealing with class third, when the fetus is expelled, but the placenta shut up in the uterine cavity, obstetricians must choose whether they will "do nothing," relying upon rest and opiates, or mechanically dilate the cervix, perhaps, with a sponge tent, and, as they say, "let nature take its course," or they *may remove* the placenta within twenty-four hours after the expulsion of the embryo, using dilators for some hours before operating, or dilating with the finger and immediately extracting.

On these points of procedure the most distinguished obstetricians and gynecologists in the country differ.

It has been urged in objection—

1. It is unnecessary, since the vast majority of patients do well if let alone.
2. It is the finger, curette, or forceps that does the damage, rather than the retained placenta.
3. It is very difficult, perhaps impossible, to remove an adherent placenta, and septicemia can be caused by a placental tuft as surely as by the entire organ.

To these objections the Doctor replied :

1. These tonic contractions are essential to the arrest of hemorrhage; there cannot be tonic contractions until the placenta is expelled, and the less will be the hemorrhage existing or possible.
2. Anxiety in both patient and physician will be prevented by early completion of the abortion.
3. Time is gained in uterine involution.
4. Absorption of putrilage from retained secundines is unquestionably the most frequent sequel in abortion; when the uterus is thoroughly disinfected, septicemia is evidently imaginary. Possible accidents from manipulation are not a sufficient reason for permitting a placenta to be removed by decomposition, ignoring the fact that self-imprisonment must be imminent; by early removal, therefore, of the placenta, septicemia is prevented.
5. Clinically, after abortion, metritis can rarely be traced to direct mechanical violence. If lesions have occurred in the process of extraction, infection in an empty uterus must be slight when compared with one in which the entire absorbing surface is exposed and covered by a decomposing placenta.—*Phil. Med. News.*

GALACTAGOGUE.—H. B. Percet (*Therap. Gazette*) thinks he finds in fluid extract of *jaborandi* valuable galactagogue properties. Dose, ten to fifteen drops.

THE BIRTH OF AN ELEPHANT.—Dr. Gustavus E. Sussdorff, of New York, contributes to the July number of the *New York Medical Journal and Obstetrical Review* an account of the process of parturition as it took place in the case of the elephant "Queen" last February. The period of gestation was 597 days. There was no noticeable enlargement of the abdomen until it became very prominent the day labor began. This enlargement did not subside with the expulsion of the fetus and after-birth, but continued four days longer. During the latter months the mammæ became swollen, and soon filled with serous milk. These were the only signs of pregnancy to be seen. The labor began at 3 P. M., February 2d. At this time the mammæ were greatly distended with milk, which came away continuously in drops. The vagina now began to drop down and swell. In a short time thick mucus began to come from the vagina in long ropy strings, and almost poured out just before delivery. From 3 until 8 o'clock "Queen" was evidently uneasy, as she constantly moved her body from side to side, but did not seem to suffer pain, and quietly munched some hay up to the moment of delivery. At 8.10 the young elephant was born, the head presenting, completely enveloped by the nn-broken membranes. The head and part of the body rested between the hind legs of the mother, and touched the ground. Without waiting a moment, the mother ruptured the membranes with her two hind feet, when the young one rolled out, on its back. The membranes were no sooner liberated than they quickly returned into the vagina. The umbilical cord had not been seen at all, having probably been torn away during the descent of the fetus. The mother now quickly turned to the young, and, on seeing it, began to roar and bellow furiously, which she continued for ten minutes. As soon as she saw the baby she also placed one fore-foot on it and rolled it several times, as one does a lemon under the palm of the hand, the bellowing and roaring continuing. In a moment or two more she placed her abdomen upon a short post in the ground, to which she was chained, standing almost upon her head, and grasping the post with her trunk, thus forcing the abdomen with great power against the post. "Queen" remained in that position for about ten minutes; then became quiet, and, while playing with her young, took some food. Nothing indicative of after-pains could be recognized after this, and in one hour and thirty minutes the placenta was expelled. With it there came about two quarts of clotted blood. There was no hemorrhage either from the uterus or from the umbilicus of the calf. The duration of labor was five hours and ten minutes. The calf, a female,

weighed 245 pounds, and stood just three feet high. It began nursing one hour and forty minutes after birth. It had two middle upper teeth. The umbilical cord entered the abdomen about three inches anterior to the vagina, and had been detached very close to the abdomen, as none was visible at that point, the canal being open and large enough to admit a good-sized finger for half an inch. Dr. Sussdorff remarks that there are several very interesting and instructive points in this history. First, the period of gestation is evidently not affected by change of climate and captivity, lasting about nineteen and a half months. The time of labor is short, and evidently there is not much pain. The sagacity of the animal is remarkable, as shown by the manner in which she ruptured the membranes, the means she took to excite respiration by rolling the young, and, finally, her effort to express the placenta from the uterus. He then describes the placenta and the fetal membranes, comparing them with those described by Owen, and adds a summary of various observations that have been made of the milk of the elephant as compared with that of other animals, giving drawings which show its microscopical characters in comparison with those of cow's milk.

CHANCRES OF THE CERVIX UTERI.—Dr. Marcek (*Arch. Derm. Syph.*) reports twenty-four cases of chancre on the vaginal portion of the cervix. In most cases the lesion was upon the anterior lip and on the os.

The earliest stage does not present the characteristic appearances—induration, sharp, livid border, diphtheritic deposit—which the ulcer assumes at a later period. Several tubercles are often found in the vicinity of the lesion. Inguinal glandular swellings and papulae about the labia and vestibule are not infrequent. If the consecutive symptoms of syphilis are already present the vaginal portion is firm, enlarged, the tubercles have ulcerated bases covered with bleeding granulations. If the initial lesion is situated in the cervical canal, it can of course only be discovered after ulceration or sloughing of the os. Its progress may be entirely free from symptoms. It is generally so slow that the primary lesion may still be present when the secondary symptoms have already disappeared. Cicatrization of the sore proceeds slowly and may be frequently interrupted or retrograde. Stenosis and atresia of the cervix have been observed in cases. The hypertrophy and induration of the cervical tissue may cause dystocia.

The treatment is principally local; vaginal irrigation, three or four times a day, with one per cent. solution of potassium chlorate or carbolic acid;

tampons saturated with solutions of iodine, chloride of iron, and iodoform; if much infiltration of the cervix exists, painting with tincture of iodine or bichloride of mercury solution (1-10). Exuberant granulations are touched with solid silver nitrate. Stenosis of the cervix is remedied by the insertion of tents. The usual constitutional treatment is pursued.

RUPTURE OF UTERUS—PARTIAL ESCAPE OF FETUS—MISSED LABOR.

—This case is detailed in the *Philadelphia Reporter* of July 8, '82. The patient, when within a week of confinement, fell against a chair, the back of which was broken off except two uprights, one of which entered her side, piercing the uterus. The fetus partially passed through this opening into the abdominal cavity. The woman recovered promptly, the extra-uterine portion of the fetus evidently becoming encysted. Labor was "missed," menstruation coming on in three months. She carried the fetus for five years, when, following, and incident to, an illness on her part, it commenced to break down and come away per *vias naturales*. It was finally removed by means of polypus forceps, the cervix being incised to the vaginal junction, by Prof. Goodell. The opening into the cyst could then be distinctly made out by the finger introduced into the uterine cavity. The patient was suffering greatly from septicemia, but finally made a tedious recovery.

EXTRA UTERINE PREGNANCY.—Dr. A. Hurd, of Findlay, O., reports two cases in the *Detroit Lancet*. Both patients died of septicemia and exhaustion. In the first, the patient lived 14 months after the supposed pregnancy. Bones were passed per rectum, but no post mortem was allowed.

In the second case, the patient lived for about four years. Fetal debris pass by urethra and bowels. At the autopsy it was found that the case had been one of double, or twin, ventral pregnancy. Dr. Hurd has been unable to find a similar case on record.

PROCIDENTIA OF GRAVID UTERUS.—In connection with the very interesting case of this kind, published by Dr. Ross in our present issue, we would draw the attention of our readers to the case published by Dr. Percy Boulton in the *British Medical Journal* for 11th March last, in which the womb became procident between the third and fourth months of gestation and could not be returned. The fetus was carried to full term in the prolapsed uterus, "which reached down to the hamstrings,"

and was not unlike a cow's udder. Dr. Lowe, of Lynn, attended the patient, and saw the fetus and placenta pass straight from the uterus, without, of course, traversing the pelvis. "The labor was short, easy and quick." Dr. Boulton suggests the possibility of producing artificial prolapse in certain cases as an alternative for craniotomy.—*Canadian Journal of Medical Science*.

MEDICINE.

PHYSICAL DIAGNOSIS.—I have often felt, when seeing hospital patients worried by hammering and long-listening to their breathing, in order that the physician might map out nicely the diseased territory, the boundaries of which he could not alter, as if it was too much like the indulgence of an idle and worse than idle curiosity. A confessor may ask too many questions; it may be feared that he has sometimes suggested to innocent young creatures what they would never have thought of otherwise. I even doubt whether it is always worth while to auscult and percuss a suspected patient. Nature is not unkind in concealing the fact of organic disease for a certain time. What is the great secret of the success of every form of quackery? *Hope kept alive*. What is the too fatal gift of science? *A prognosis of despair*. "Do not probe the wound too curiously," says Samuel Sharp, the famous surgeon of the last century. I believe a wise man sometimes carefully worries out the precise organic condition of a patient's chest when a *very* wise man would let it alone and treat the constitutional symptoms. The well-being of a patient may be endangered by the pedantic fooleries of a specialist.—O. W. Holmes, in *Bost. Med. and Surg. Jour.*

PNEUMONIA AFTER OPIUM POISONING.—Dr. A. B. Isham (*Cincinnati Medical News*) relates two cases in which patients poisoned by opium were treated by exercise, flagellation and violent exercise, and developed pneumonia. Dr. Isham is inclined to think that the excessive douching, exercise and flagellation commonly used are liable to produce serious results, as in these cases, and that caution is necessary.

THE DIFFERENTIAL DIAGNOSIS OF TYPHOID FEVER AND TUBERCULAR MENINGITIS.—(Dr. Lambert Ott, *Med. Times*.) My attention has been called to this subject, at the bedside, by noticing what a similarity of symptoms existed in the diseases in question in the incipient and more

advanced stages. I, with other physicians, have left the bedside of a child presenting symptoms pointing to either disease, in which it was impossible to make a positive diagnosis. In both there are irritability, headache, vomiting, diarrhea or constipation, loss of flesh, anorexia, and evidences of constitutional disturbances. In the incipient stage, when the child shows this array of symptoms, the physician meets with great difficulty in coming to a definite conclusion. When the diseases are more advanced—the case of tubercular meningitis being in a stupor and that of typhoid fever in a somnolent state—our judgment is often taxed to decide. From full notes of a number of cases of typhoid fever and tubercular meningitis, ranging in age from 11 months to 8 years, I have formulated the following differential diagnosis:

INCIPIENT STAGE.

TUBERCULAR MENINGITIS.

There is a gradual loss of flesh, extending over some weeks or months.

Irritability more intense and prolonged; restless during sleep.

Shunning light is common.

Temperature has no characteristic change; may be high in the morning and low in the evening, or the same morning and evening.

Vomiting causeless, and not connected with ingesta. May find a clean tongue.

Headache not aggravated at any particular time of the day.

Nearly always constipation.

No abdominal tenderness.

Pulse of good volume, moderately slow, and occasionally irregular.

No epistaxis.

TYPHOID FEVER.

Loss of flesh only apparent after fever-process has existed some time.

Irritability not so intense; quieter during sleep.

Absent.

Typical fever-curve; gradual ascent, having low fever in the morning and higher in the evening.

Vomiting nearly always connected with curdled milk or repugnant medicine. Coated tongue.

Headache always aggravated, towards evening, when the fever ascends.

Diarrhea, as a rule; exceptionally, constipation.

Abdominal tenderness and tympanites.

Pulse soft, rapid, and never irregular.

Often epistaxis.

ADVANCED STAGE.

TUBERCULAR MENINGITIS.

Irregular temperature curve or no fever at all.

Now the vomiting generally ceases.

Stupor is continual, patient not easily aroused, and immediately falls back again into his former state.

Obstinate constipation.

Retraction of abdomen.

Tache cerebrale; sudden and spontaneous blushing of the cheek, and of parts exposed to pressure.

Cheyne-Stokes breathing.

Pulse very irregular.

Spleen normal.

Local palsies and local spasms; fixedness of the eyes; unequal or dilated pupil.

Extreme tenderness elicited on pressure of the femur.

Urohematin, but no albumen or indican in the urine. (Robin)

TYPHOID FEVER.

Continued fever, stationary, or ascending gradually with the morning remission.

May have vomiting of ingesta.

Is easily aroused; remains awake for a time and requests drink. Is usually rational during the time of being awake.

Generally diarrhea, yellow or brownish stools.

Tympanites and tender abdomen.

Roseolar eruption.

Breathing at times very irregular, quite sighing, but not the rythmical irregularity. One day regular and the next very irregular.

Pulse weak and regular.

Spleen enlarged and tender.

No such manifestations.

No tenderness on pressure.

Indican and albumen always present in the urine. (Robin.)

One symptom—that of distress elicited by pressure on the femur—is an incidental discovery of mine, and came to my notice in the following manner: While examining a case of tubercular meningitis in the stage of stupor, I was desirous of awakening the child for the purpose of witnessing the mental phenomena. To accomplish this, I surrounded the thigh with my hand and squeezed it moderately hard, which caused the child to utter a piercing scream. As this seemed out of all proportion to the amount of injury inflicted, I repeated the pressure in a less degree, and the same out-

cry was provoked. Seizing other parts of the extremities with the same amount of force caused no disturbance whatever. I repeated the experiment in a second case, and found a similar manifestation, while pressure on other parts produced no such effect.—*Am. Med. Digest.*

LARGE DOSE OF CHLORAL.—Dr. Madigan, of Brooklyn, reports the case in the *Chicago Review*. A drunken doctor gave an insane patient *one ounce* of chloral in solution in water. The state of affairs being discovered after a time, aid was called and a stomach pump used, also hypodermic injections of whiskey and strychnine. Patient slept 48 hours, and recovered. Had scarlatiniform eruption on third day, followed by complete desquamation.

PREVENTING BOWEL DISEASES IN INFANTS.—Dr. N. S. Davis, in a paper read before the American Medical Association, states that our efforts to lessen infant mortality from these diseases must embrace such measures as will secure for young children a better supply of fresh, pure air, for increasing the oxygenation and discarbonization of the blood and maintaining the activity of the vaso-motor nervous system, and as well counteracting the effects of high temperature by increasing the general tonicity and lessening the excitability of the tissues generally. Measures for the first object must consist in securing better ventilation of dwellings, and especially nurseries and sleeping rooms, during the warmest part of the summer, the sending of young children with their mothers and nurses from densely populated districts to moderately elevated, healthy locations, or to floating hospitals, receiving ships, or large bodies of water, during the special period of high heat. For accomplishing the second purpose, he knew of no measures so efficient and at the same time within the reach of the poorest part of the population, as the judicious use of the *sponge bath*. Whenever the human system is relaxed and rendered morbidly sensitive by continuous high heat, causing the infant to be languid, restless, and sometimes pale, a free bathing or sponging of the whole surface with water simply as cool as it is comfortable always produces a refreshing and invigorating influence, which continues from six to twelve hours. Consequently, if mothers and nurses could be so instructed by their family physician that, during every wave or period of high atmospheric temperature in which the mercury did not fall below 70° F. during the night, each child under two years of age should be regularly given a bath in the evening as well as in the morning, and their sleeping rooms should be as

well ventilated as possible, such a course would diminish the attacks of serious diarrhea and cholera infantum one-half, and consequently very greatly lessen the infant mortality from these affections.

It is well known to every careful observer that a large majority of all the attacks of this form of disease show their first beginning during the last half of the night or early in the morning, owing to the long continuance of the high temperature, coupled with the more still and confined air of the night. The increased tone of the whole vascular system produced by the stimulant and tonic effect of a comfortably cool sponge-bath on the function of the vaso-motor nerves, applied in the evening, would enable thousands of these little restless sufferers to pass the whole night unharmed, when without it the dread weakness would begin.—*Sanit. Engineer.*

DIALYSED IRON IN THE TREATMENT OF ARSENICAL POISONING.—A. M. Bullard, M. D., of Wickes, M. T., writes as follows to the *Philadelphia Reporter*: In the smelting of lead and silver ores, one of the worst features is the constant inhalation of arsenical fumes. When first employed by the Alta Montana Company to take charge of their hospital, a number of cases of arsenical poisoning came under my observation, and they were the more difficult to treat on account of their complication with "leading." I tried the various remedies recommended for such cases, with but poor results. At last I was led to try dialysed iron, and was met in all cases with most gratifying success, as is evidenced by the following cases:

Two carpenters were engaged in roofing a portion of the smelting building, and were in such a position that the wind carried the fumes into their faces. Some workmen below noticed one of the men swaying to and fro, and about ready to fall, while the other was laboring hard to reach the ground. They were helped to the hospital, and were suffering with severe pain in the stomach and bowels, nausea, vomiting, vertigo, and with a profuse "nose-bleed," tremor in lower limbs, and almost prostration. A wine-glass full of dialysed iron was given immediately. The nausea ceased, and at the end of one hour the men were able to walk to their cabins, carrying with them a bottle of the iron, to be taken in drachm doses every half hour. At the end of twenty-four hours they complained only of weakness, such as would result from a severe diarrhea. The second day they resumed work, perfectly free from all pain and effects of the arsenic. I have recommended and, indeed, insisted on, every man who is exposed to the arsenical fumes, taking a dose of the iron daily. The

consequence has been, that we have had but one case of poisoning needing hospital treatment, and this one insisted that his case was one of "indigestion and dyspepsia," and would take nothing until compelled to enter the hospital, where, under the administration of dialysed iron, he speedily recovered.

In the past two years I think I am safe in saying that fully two hundred cases of arsenical poisoning have been cured in this camp by dialysed iron. I could cite any or all of them, with symptoms, treatment, etc., but I think it unnecessary as they so nearly resemble those already mentioned; suffice it to say that all experienced the nausea, griping, vomiting, muscular tremor, etc. I have given the iron, in half-ounce doses, three times daily, with no constitutional disturbances whatever, even after ten and twenty days' administration. The teeth are not discolored, bowels not constipated, and digestion not deranged.

The men have learned its virtues, and come regularly with "please fill my iron bottle again." They will not do without it, any more than an Irishman will do without his "salts and senna." It has saved many a man his wages and many a day of sickness. In fact, I feel convinced that this preparation is indispensable where men are liable to inhale the fumes of arsenic.

Without a remedy of this kind, I am satisfied no man, however strong, could inhale the fumes incident to smelting, where the ores contain arsenic, and stand it more than three or four days. I can confidently recommend this preparation of iron to the profession, and to foremen of smelting works.

The preparation which I have used, and to the good effects of which I can testify, is Wyeth's, of Philadelphia.

SIMPLE MEANS OF DETECTING TRICHINA.—According to Prof. Phin, the parts of an animal that should first be examined are the diaphragm, tenderloin and muscles about the head and throat. In a ham, the most likely place is that at which the muscle ends in a tendon. Cut off a thin slice with a very sharp knife, or with a pair of scissors curved on the flat. This thin section should then be soaked for some minutes in acetic acid, spread out on a thin piece of glass, and covered with another similar piece. These two slips are then pressed together. A compressorium, by means of which the plates of glass are forced together by a lever and screw, answers admirably. But better still he finds the trichinoscope, which is a compressorium holding the two glass slips, but fitted with a

simple microscope on a sliding frame, which permits the examination of the specimen in each part. A thin piece of flesh, moistened with a mixture of equal parts of acetic acid and glycerine, is placed on the lower plate, and spread by means of needles fixed in wooden handles. The upper plate is then brought down on the lower one, and the screw is turned into the slot in which it fits. By turning the nut any degree of pressure may be brought to bear on the flesh, which thus is rendered so thin and transparent that any trichinæ present will be readily brought into view.—*Boston Journ. of Chem., Phil News.*

EPIDEMIC CEREBRO-SPINAL MENINGITIS.—The seventeen cases which Jaffe relates (*Deut. Arch. f. klin. Med.*), and which were mostly observed by himself, are not recorded for the purpose of setting up new theories concerning cerebro-spinal meningitis, but are intended to correct many errors which exist in regard to etiology, etc. He, therefore, first gives a summary of cases of like nature and of the results of all observations. The author maintains that the meningitic virus is a specific one, and considers it a waste of time to endeavor to prove its connection with other infectious diseases. It is certain that the disease in question is a specific infectious one, which may occur sporadically as well as epidemically, and may be spread by contagious as well as by miasmatic influence. As we are not yet clear as to the nature of the virus, we must, for the present, consider the two questions, as to the origin of the virus and the etiology of the disease, as unanswered; but, as a fact, we can record that it exists, and, as probable, we may assume that it is less a miasma than a contagium. Whether it be fixed or volatile, whether "vivum" or otherwise, or if parasitic, we know not as yet. Jaffe has examined, microscopically, the blood and exudations found in the cerebro-spinal cavities, but has found no organisms of any kind. He feels himself justified, therefore, in denying that cerebro-spinal meningitis is a parasitic disease (from a modern point of view).

Prodromal symptoms were found in ten cases. Headache occurred in fourteen, vomiting in fourteen, and delirium in ten cases; the latter two were of a maniacal character, and had been admitted as suffering from delirium tremens. Episthotonos occurred sixteen times; hyperesthesia, eight; anesthesia, once only: ocular changes, ten times; aural troubles, once, in the form of purulent otitis media, with perforation of the membrana tympani. In two pneumonia, in one bronchitis, and in one gangrene of the lungs occurred. There were two cases of ulcerative endo-

carditis, complicated once with purulent pericarditis. Splenic swelling was observed thrice, passive albuminuria once, arthritic affections five times.

The duration was two or three days as the minimum, four months as the maximum. Ten cases ended in death, seven in recovery; the mortality being 58 per cent. The diagnosis is most difficult in the early days of the sporadic cases. We have to distinguish between the diseases idiopathic (traumatic) spinal or cerebro-spinal meningitis, tubercular meningitis, as two of the reported cases show. Typhoid fever is recognized by the gastric symptoms, which soon appear, and the absence of spinal symptoms, as well as the presence of the splenic tumor; intermittent fever by the beneficial effect of quinine. The other diseases are distinguishable in their further progress.

The treatment consisted in the application of ice to the spine and administration of narcotics, calomel in large doses, lukewarm and cold baths. The author found abstraction of blood, prolonged baths, and the administration of antipyretics to be useless, the latter disturbing the digestive faculties and lowering the patients.—*London Med. Record.*—*Phil. News.*

COFFINISM.—A fatal case of poisoning by lobelia inflata is recorded in the *British Medical Journal* of July 1st. The patient was a man of intemperate habits in drink and an enormous eater. He had for some months been suffering with heart disease, and often complained of a severe burning pain in his stomach. In this condition he fell into the hands of the "Coffinites," and on the day of his death had taken an emetic consisting of lobelia and cayenne, which failed to produce emesis and induced a state of intoxication from which he died. A post mortem was made twelve hours after death, when the pupils were found slightly dilated, the lower jaw firmly fixed and the abdomen greatly distended. A further examination revealed the intestines much congested in places, and an aperture as large as a goose-quill in the lesser curvature of the stomach, through which about two pints of fluid of a milky appearance had probably escaped into the peritoneal cavity. In the cavity of the stomach was found half a pint of yeasty fluid, in which lobelia-seeds and pieces of cayenne were to be seen. The lungs were healthy, but the heart was fatty.

A coroner's jury returned a verdict of death from perforation of the stomach induced by the action of an emetic containing lobelia, which the deceased had judiciously taken.

The Coffinites, who take their name (a very suggestive one in the

light of the above case) from one Dr. Coffin, seem to be near relatives of the Thompsonians, once well known in this country. Their creed is rudimentary and their therapeutics simple. Acting upon the dictum that "heat is life," and that "the want of heat was disease and death," they give lobelia and cayenne in all cases coming under their care, regardless of the condition of the patient. They confidently assert that lobelia cannot kill, but it has been shown over and over again that when the drug fails to be rejected by the stomach it acts as a powerful irritant and depressant, and kills with the greatest certainty.

While cases such as the above may not teach the physician any thing new regarding this powerful and dangerous drug, they may serve him a useful purpose for reference in warning the laity against its popular use. Lobelia not many years ago was as much the sheet anchor of those who practiced the Thompsonian method of treating disease as was ever aconite in the hands of the homeopaths, with this count in favor of the latter, that it was given in doses too minute to injure the patient, while lobelia in strong decoction was poured down the throat of the sick man *ad libitum*, bringing away from his stomach every thing it contained down to the basement membrane, and leaving him in a state of prostration which none but the victims of this drug or of the first overdose of tobacco could appreciate.

The lineal descendants of Thompson, our brothers the modern eclectics, have drifted away from this mooring; at least we rarely observe any allusion to the abomination in the eclectic journals; but still among the books on domestic medicine in many families may be found a treatise by some disciple of Thompson, with a large engraving of the lobelia for a frontispiece, the pages following being devoted largely to laudation of the drug, with directions for its employment in heroic doses in almost every affection described. Besides these, there is in every town, especially in the Northern States, a traditional follower of the Thompsonian school in the person of some benevolent old lady who always keeps a bunch of lobelia hanging in her garret, and who administers it to her family or her neighbors, when any of them are taken sick, as a preliminary measure, or by way of diversion before the doctor arrives.

The physician who is plagued by this phase of domestic practice can do much for suffering humanity, and materially reduce the popularity of this barbarous plant, by always having in his medicine case an antidote for lobelia, and at his tongue's end a long list of the deaths it has caused.

—*Louisville News.*

DIAGNOSIS OF YELLOW FEVER FOR SANITARY PURPOSES.—Dr. S. M. Bemiss, in an excellent paper read at the late meeting of the Louisiana State Medical Society (*New Orleans Med. and Surg. Journal*, May, 1881), laid down the following propositions, which were unanimously endorsed by the society:

I. For sanitary purposes the following groups of symptoms shall be considered to indicate yellow fever:

Group 1st.—A person after (a) a sudden attack, has (b) a fever of one paroxysm, attended with (c) masked congestion or blood stasis of capillaries of surface, conjunctivæ, and gums; with (d) a history of probable exposure to infection, and (e) no history of a previous attack of yellow fever.

Group 2nd.—A person after (a) a sudden attack, has (b) a fever of one paroxysm, followed by (c) unusual prostration, (d) albuminous urine, (e) yellowness of conjunctivæ, or skin, and having no positively authenticated history of previous attack of yellow fever.

Group 3rd.—A person has (a) a fever of one paroxysm, (b) albuminous urine, (c) black vomit, or (d) suppression of urine, (e) general hemorrhagic tendency under (f) circumstances where exposure to infection is a possibility.

II. Suspicious cases of yellow fever for sanitary purposes.

The following symptoms associated with a fever of one paroxysm in a patient who has apparently been exposed to infection and has never had yellow fever, shall be held to justify in either of the six following cases a suspicion of this disease, viz.:

First, suddenness of attack either with violent pain in the head and back, injected eyes and face, or with marked congestion of the superficial capillaries.

Second, want of correlation between pulse and temperature usual to other forms of fever.

Third, albuminous urine.

Fourth, black vomit.

Fifth, general hemorrhagic tendency.

Sixth, yellowness of skin

The following cases shall also be deemed suspicious:

Seventh, any case respecting which reputable and experienced physicians disagree, as to whether the disease is or is not yellow fever.

Eighth, any case respecting which efforts are made to conceal its existence, full history and true nature—in violation of Sec. 27, City Ordinance, June 24, 1879.

In the event of death of a suspicious case, a *post mortem* examination should be made when practicable. Both before and after death, yellow fever is specially and pre-eminently characterized by the fact that it is, *par excellence*, a hemorrhagic fever, marked by capillary congestion and its sequelæ; hence, *post mortem* evidences of a general hemorrhagic tendency in internal organs, especially in the digestive in preference to the urinary tract, shall be held to confirm the suspicion.—*So. Practitioner*.

EXCESS OF FAT.—Dr. George Johnson's diet for excess of fat.—The patient *may eat*: Lean mutton and beef, veal, lamb, tongue, sweetbread, soups, not thickened, beef tea and broths, poultry, game, fish, cheese, eggs, bread *in moderation*, greens, spinach, watercress, lettuce, asparagus, celery, radishes, French beans, green peas, Brussels sprouts, cabbage, cauliflower, onions, brocoli, seakale, jellies, flavored but not sweetened, fresh fruit in moderation, without sugar or cream, pickles.

May not eat: Fat bacon and ham, fat of meat, butter, cream, sugar, potatoes, carrots, parsnips, beetroot, rice, arrowroot, sago, tapioco, macaroni, vermicelli, semolina, custard, pastry and puddings of all kinds, sweet cakes.

May drink: Tea, coffee, cocoa from nibs, with milk, but without cream or sugar, dry wines of any kind, in moderation, brandy, whisky or gin, in moderation without sugar, light bitter beer, Apollinaris water, soda water, seltzer water.

May not drink: Milk, except sparingly, porter and stout, sweet ales, sweet wines. As a rule, alcoholic liquors should be taken sparingly and never without food.

CELERINA.—I have used Celerina in several cases of nervous exhaustion with good results. It contains celery, coca and viburnum, excellent drugs that are often indicated in such cases. D. R. Brower, M. D., Editor Chicago *Medical Examiner* and Professor of Nervous and Mental Diseases, etc. Woman's Medical College.

REVIEWS AND BOOK NOTICES.

Prices are always inserted when furnished by the publisher, or when obtainable from the bookseller.

Rhode Island State Society, 1881. Pp. 84.

Dr. E. M. Snow, Supt. of Health, of Providence, has always taken pains to use only the pure humanized vaccine virus; taking great care never to get it mixed with the modern "bovine", so-called. Thinks the virus now in his office is probably the only true humanized virus in the country. He finds it to produce typical local and constitutional effects. Has had no personal experience with bovine virus, but thinks it very uncertain in its results, and liable to fail in affording protection.

The President's address, by Charles O'Leary, M. D., is on the *Use and Abuse of Medical Charities*. After giving a history of the rise of hospitals, he proceeds with some startling statistics. London give gratuitous medical relief to one in every three and one-half of its inhabitants; New York to one in four; Boston, one in four and a half; Philadelphia, one in five. The number thus applying for relief has increased, in these cities, 50 per cent. within the past ten years, which is out of all proportion to either the stringency of the times or the increase of population. Medical relief has been so forced upon the poor and middle classes that what would once have been regarded as humiliating is now accepted as a matter of course. But this is only the beginning of the evil:

"Physicians and surgeons of dispensaries and of out-patient departments of hospitals, cannot fail to be impressed with the striking change in the demeanor of many patients who have become habitual recipients of medical charity. When they apply for it on the first occasion, they evince shame and apologize for coming, and in some cases give satisfactory proof that they have maintained their independence as long as they could; but when they have experienced how easy it is to get medical advice and medicine without paying for either, and when they find in the waiting-room many persons whose position in life is similar to their own, "Goitre keeps Goitre in countenance," their views regarding medical charity are modified, they become habitual recipients, their feelings of independence are deadened; the workman and his wife may thus learn at the hospital the first lesson of dependence, and take the first step downward into the habits of pauperism. They commence by begging physic, they may end by begging the other necessities of life, and pass from independence to pauperism."

The remedy suggested is that laws be enacted making the impostor who, under pretense of poverty, steals the funds devoted to medical relief,

as much a criminal as he who obtains any other valuable consideration under false pretenses. A few cases sharply dealt with would soon stay the tide, and enable the really needy to be all the better cared for.

The papers on Abscess of the Liver, and Purulent Middle Ear Catarrh, contain nothing new whatever.

The paper by Dr. Chapin, on Malaria in Providence, is undoubtedly of local interest, but we of the West are long since familiar with all its statements. The same may be said, indeed, of the next paper, on Malarial Keratitis, by Dr. H. G. Miller.

The next, and last, paper is on the Treatment of Puerperal Convulsions, and is based *on a single case!*

Rhode Island, considering its size, has fully come up to the average in its *Transactions*.

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HANN & ADAIR, Publishers, Columbus.

THE MURDEROUS TOY PISTOL.

A daily paper, just received, contains the startling announcement that "247 deaths have thus far resulted from tetanus following wounds inflicted by the toy pistol on the Fourth." Two deaths have occurred from this cause in this city, and all cities seem to have suffered more or less.

The pistol is a rudely-made affair, costing only twenty-five cents. The cartridges used resemble the ordinary No. 22, except that there is no bullet, its place being taken by a pasteboard wad, though boys not infrequently drop into the barrel, on top of the wad, a pebble or some metallic

body. The lock is a poor one, and very liable to slip. As the pistol is ordinarily held in the act of loading and cocking, the palm of the hand is so situated with reference to the muzzle as to be wounded if premature discharge takes place. This seems to be the explanation of the frequency with which these wounds are inflicted. No satisfactory explanation has yet been offered for the frequent occurrence of tetanus after the injuries, save that the wound is in the palm. The wound is a ragged one, and the opening through the skin is not as large as the cavity beneath—as though the force of the explosion had not had time to spend itself at the surface—while within there is found, generally, the wad and the *debris* of the powder. The wound seems so trifling that the friends do not think it necessary to call for professional aid, or, perhaps, even the physician treats it slightly, with a simple direction to apply cold water, and as a result the wound is not thoroughly cleaned, if indeed cleaned at all, but the irritating remains of the explosion are left to commence their fatal work; for while these wounds are not by any means always followed by tetanus, no cases, have, we believe, been reported where recovery has taken place after tetanus has commenced.

The indications, therefore, seem plain as to the treatment of the wound, (for prophylaxis seems to be impossible in the case of the American small boy,) namely, to open the wound through the integument to the full size of the excavation beneath, and to then thoroughly remove all foreign matters. Perhaps in addition, and out of deference to the prevailing fashion, the wound might then be stuffed with iodoform, but we regard this as, to say the least, immaterial.

VERIFICATION OF THERMOMETERS.—The report just received of the Observatory of Yale College, shows that more than double the number of physicians' thermometers were tested at that institution last year over the year before. So great errors have been found in some instances, that hereafter the physician who reports an extreme of temperature will be in duty bound to report whether or not his thermometer is a reliable one. One instrument was found that was *four and one-half degrees* out of the way!

Public opinion has already reached the point when it demands that the physician shall have a thermometer; it will not be long when it will require that his thermometer be a tested one. A case that recently occurred in the writer's practice will serve to illustrate the fact that the hand is, under certain conditions, a very poor test of temperature. We were

called hastily to see the patient of another physician, during his temporary absence. The patient was dying. The pulse was 240 per minute, and the temperature 106° in the axilla, *by a verified thermometer*. The attending physician came in just as the instrument was being withdrawn, and, after examining the patient, expressed the opinion that the temperature was *sub-normal*. He is a skillful practitioner, and never depends upon his temperature sense, knowing too well how fallacious it is. The patient died within an hour.

RESPONSIBILITY OF A DRUGGIST.—A patient, Mrs. R—, went to a drug store in New York with a prescription for laudanum, of which the druggist was directed to give her sixty drops at once. The druggist refused to give her but ten drops. She went home, took the medicine, and had a miscarriage. She then brought suit against the druggist for \$10,000 damages, claiming that if she had had the sixty drops the miscarriage would not have occurred. The defence was that the ten drops of laudanum could not have affected her further than to temporarily lessen her pain, and that a druggist is not bound to personally administer dangerous drugs upon the order of a physician, his duty being simply to prepare medicines under the direction of physicians. Judge Beach sustained this view of the duty of a druggist, saying that such a tradesman would incur liability to indictment for manslaughter for having knowingly administered a drug or medicine which produced death. A large number of physicians were present, and most of them expressed the opinion that a miscarriage would have happened, even if sixty drops of laudanum had been administered. The jury gave a verdict for the druggist.

About six thousand new doctors are every spring thrown out to seek a living by absorbing a portion of the practice of those already in the field. By a recent calculation from admitted data, each doctor in the United States would have two paying patients, if they were equally divided. What are the new men to do?

BATTEY'S OPERATION.—This operation was recently performed in this city. The patient, aged about 23, died in 36 hours. We are unable to give the reasons which led to the operation, except that the patient had persistent vomiting. The ovaries were easily found and removed, although adhesions had been anticipated, and they presented little gross appearance of disease.

PAPER-SOAP.—Dr. Addinell Hewson, of Philadelphia, has recently found that tissue and manilla paper can be so impregnated by immersion in a hot solution of English glycerine soap, that a slip the size of a visiting card will answer for washing the hands or shaving. This furnishes not only a great convenience to travelers and others, as well as a saving of soap, but also a way of preventing contamination both in public and private.

TO DISGUISE THE ODOR OF IODOFORM.—A Philadelphian directs his patients to spread some of the ointment on a piece of muslin and bandage a finger with it. The stuff will smell just as strong as before, but the patient will be able to assume a virtue, if he has it not, and to comply with the Biblical injunction—to “avoid even the appearance of evil.”

NOTICE TO GRADUATES OF BELLEVUE HOSPITAL MEDICAL COLLEGE.—A second decennial revision of the Catalogue of Alumni of this college is being prepared for publication, and we are requested to ask that all graduates send their present address, at once, on a postal-card, to the Historian of the Alumni Association, Bellevue Hospital Medical College, New York.

DEATH OF PROF. MUSSEY.

Just as we go to press the newspapers inform us of the sudden death of William Heberden Mussey, M. D., of Cincinnati.

Dr. Mussey was born in New Hampshire, September 30, 1818. He graduated from the Medical College of Ohio in 1848. After spending two years in Paris he settled in Cincinnati. In 1865 he was elected Professor of Surgery in the Miami College. A few years ago he donated to the public library of Cincinnati several thousand volumes of medical works as the foundation of the “Mussey Medical and Scientific Library,” which he designed as a memorial of his distinguished father.

He died of apoplexy, on the 1st inst.

NOTES AND COMMENTS.

A dandelion stalk is the latest emergency substitute for a catheter.

RETIREMENT OF LANGENBECK.—Professor Langenbeck is soon to retire from his Professorship in the Medical Faculty of Berlin.

The physican sees man in all his weakness; the lawyer sees him in all his wickedness; the theologian sees him in all his littleness.—*Schopenhauer*.

Professor Bigelow has resigned the Chair of Surgery in Harvard University. His successor has not yet been appointed, but will almost certainly be David W. Cheever, now Professor of clinical surgery.

The representative of the Hoemeopathic College in Cook County Hospital has resigned. The contrast in practice was too great for his sensitive soul.—*Peoria Med. Mo.*

Dr. J. G. Polhill, of Milner, Ga., writes to the *Bulletin* that he has under treatment a case of secondary syphilis, remarkable on account of the age of the patient, who is a negro woman over eighty years of age. Contracted by copulation with a negro eighteen years of age.

SUICIDE OR MURDER.—Dr. Wolff reported at the Atlanta Medical Society a case of considerable interest from a medico-legal standpoint. At a place in Texas, near the Mexican border, a boy sixteen years old was found hanging in a barn. A handkerchief encircled his neck, and was tied to a beam above. His face was downward, and was within six inches of a pile of corn cobs, upon which his feet, legs and thighs rested. At the post-mortem the stomach was found to contain only a small quantity of food, no ecchymosis on surface of the lungs, face calm, no appearance of strangulation. A protuberance was noted on the back of his neck, but no extravasation or effusion of blood. The protuberance was caused by the subluxation of the second cervical vertebra backward. A man was suspected and tried for the murder of the boy. There were no witnesses to the deed, but Dr. Wolff testified that the luxation was post-mortem, as no effusion around or about the injury was found. He illustrated his

views by breaking the necks of several dogs before and after death. These specimens were presented to the jury, and invariably sustained the position of the witness. The defendant finally confessed that he killed the boy by a blow in the hypogastric region; he then suspended the body as found, and threw his whole weight upon the back. The evidence of Dr. Wolff forced the confession and secured the conviction of the prisoner.—*Atlanta Med. Register.*

A HALF HOUR WITH OUR ADVERTISERS.

The "Royal" pepsin has so far had such excellent results following its administration in our hands, that our faith in pepsin, which had sadly waned, is now strong. It seems to be the ideal article.

The Dialysed Iron, of Wyeth & Bro., has uniformly sustained its reputation for excellence. A writer in the present issue of the JOURNAL speaks of it with unstinted praise as a ready and sure antidote for arsenic. Their elixirs are examples of elegant pharmacy, while their "tablets" should accompany every hypodermic syringe case.

A therapeutic syllogism: Hot weather; indigestion and diarrhea; *Lactopeptine*.

Those in need of a microscope, or of microscopic accessories, should correspond with the Messrs. Beck before purchasing. Their work is simply elegant, while their prices are certainly reasonable.

We greatly dislike to commend a remedy of whose composition we are ignorant, but we have over and over again give *Svapnia* in cases where all other preparations of opium had failed, and with the happiest effects.

We recently enjoyed a visit to the manufacturing establishment of Messrs. Parke, Davis & Co. The Superintendent seemed to take pleasure in showing us through the immense building, which far exceeded our expectation as to its size and the completeness of its mechanical appliances for the preparation of drugs. We may not be able to tell what becomes of all the doctors, that are annually turned loose, but an inspection of the shipping room of this establishment would convince any one that a good many of them are prescribing P., D. & Co.'s preparations. We were specially impressed with the care taken to prevent mistakes, and to secure uniformity of composition in all their products.

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COMMUNICATIONS.

HISTORY OF A PERSONAL ATTACK OF TYPHOID FEVER.

BY ALEXANDER STEWART, M. D.

Before loss of consciousness—It was in the first weeks of Dec. 1879, that I began to take less interest in my work; I felt tired sooner than usual; took my food and slept much as usual, but had less energy and less interest in my patients. As time wore on, it was with an effort I could finish what I had to do, and at night generally went to sleep on the couch. Sunday, Jan. 18, 1880, the *first definite symptoms* presented themselves—from this day I date the real commencement of the fever. I had no appetite for dinner; in the afternoon I experienced *pain* and *stiffness* at back of neck: on moving the head the pain took a shooting character. Slept tolerably well and in the morning had no inclination for breakfast or work. On the second day, could eat no dinner; towards evening *felt cold*, and could not get warm; this feature was particularly marked along the spine, and there came *pain in the small of the back* for the first time. Slept pretty well that night; was unrefreshed in the morning, no appetite. This was the third day. I felt cold and listless. I had now occasional and most acute *headache*, the pain being chiefly in left temple, and shooting through the forehead. Towards night the *lumbago* returned, was more severe, and there was a *stiffness* about the loins and hips all day. Restless night. Morning came; headache worse; had much difficulty in walking, legs so heavy and joints so stiff; lumbago continuous and very severe—more so in the afternoon and towards evening. Fifth day I was very ill

—could scarcely drag one leg after another. Sixth day the headache was incessant and excruciating, and the least noise aggravated it. Could eat nothing; had great *thirst*, drank iced milk, and sucked ice alone, which was most grateful. *Cold water cloths* had but little effect in soothing the headache; an *ice bag* for a few minutes was cool and pleasant, then the sensation of cold left, and I preferred to throw it away. If at any time this day I wished to get out of bed, my feet and legs felt so heavy, so heavy. It was troublesome to raise my head. To speak or even listen was a trouble. My mind seemed to want repose, I could not fix it, and objects appeared confused and indistinct before my eyes. Towards evening the pain left the head and attacked the dorsal region—perhaps I should say the pain in the back superceded the headache. The lumbago was hard to bear; turpentine stupes were applied and did some good. I begged to have a subcutaneous injection of morphia, but it was not considered advisable; got my landlady to rub up and down the spine most vigorously with a flesh brush; while this process continued it gave some relief. Bowels confined. At bedtime was given chloral, which had no effect either in allaying the pain or inducing sleep. Passed a restless night; was weaker on Saturday, the seventh day. In the forenoon had a black draught, which acted freely twice before night. Mr. W. F. Favell was called in, and he gave as his opinion that I had typhoid fever. I did not apprehend any danger or experience any fear of death. In fact, my senses were obtuse, except that of hearing which was preternaturally acute, and the brain was most sensitive to sound. The lumbago was severe all day, turpentine was recurred to, and in the evening an ointment of belladonna spread on lint was applied, but it became so unbearably itchy that it had to be removed. I was only partly conscious of events that occurred on this and the previous day, and my recollection of some of them is a hazy, dreamy one. Chloral was given at night with as little effect as before. I passed the eighth day in a dazed, semi-conscious condition. Bowels not moved. *Characteristic spots* detected for the first time. Lumbago was gone and I suffered no pain as long as quietness prevailed. I remember writing on a telegraph form for my brother, and I recollect no other distinct occurrence till his arrival. I remember his coming, talking a little, writing a prescription and then leaving. All seemed to take place in a couple of hours; but he remained all that night and until the following night. Another event of the ninth day, of which I have the dimmest recollection—like a shadow in the dark—was the arrival of a nurse for me. Then all consciousness of surrounding objects seems to have left me,

and I remember nothing real between then and the 19th day of illness.

To sum up the symptoms I have already mentioned, we have languor and listlessness coming on insidiously; then more definite symptoms, as headache and lumbago, both at first evanescent, but afterwards continuous. Gradual loss of energy culminating in great prostration of the physical and mental powers in the first week of the fever. We have the characteristic spots appearing on the eighth day; and the brain, so sensitive to sound, becoming weaker day by day, till, incapable of realizing surrounding objects, it governs the different members, and is governed, by the delusions of a feverish imagination, as I am about to describe.

Delirious wanderings.—I believe it was on the tenth day of illness, I imagined myself in a house, of a dirty, bedraggled appearance, in a locality of the town I knew. Thought I was left there by a cabman who occasionally took me on my rounds. As I felt very uncomfortable in this house I waited very impatiently for the cab to come and fetch me home. The cab did not come, and after a time I found myself in an uncomfortable bed in a dirty room in the same house. I was attended by a tall woman stylishly dressed, but dirty and suspicious looking. She passed in and out of the room, and every few minutes pressed me to drink milk from a feeding cup which she held to my lips. I refused to drink, as the cup was dirty—everything was dirty, and I imagined she wanted to poison me. Again and again she repeated her pressing, but I remained obstinate in my refusal to drink though parched with thirst and with a great craving for a draught of pure, cold milk. I determined not to be poisoned as long as I could resist. There was also another woman who came into the room now and then, and also pressed me to drink the milk, but unsuccessfully. She was dressed similarly, and similarly dirty to the other, but much smaller in size. On one side of my bed was a hole full of dirty water, where slops, &c., were thrown, and dishes washed; on the other side was a bed, for the use of a soldier, I thought, because beside it I saw an artificial leg. In this situation I felt most wretched, and had a great desire to get home. By this time I had given up all hope of the cab coming for me, and began to consider how I could make my escape. The tall woman was sometimes absent from the room and the door open. I wondered if I could rush through this door and find my way into the open air. I concluded the chances were against me, that I would be caught and brought back, for I had a suspicion I was being watched to prevent any attempt at escape. I then turned my attention to the window, and thought if I could only jump through it, I could run home in my night

shirt without attracting much attention in the dark. While cogitating on this point, the tall woman again entered the room, frustrating my object for the time. The thirst increased, but still I refused the oft proffered drink. About this time my landlady appeared on the scene. I implored her to have me removed from that nasty place. As she did not seem willing to do this, I requested her to go for Mr. Shaw, adding that he would take me home. She promised to go for him and left the room. On her return, after a weary waiting on my part, she did not bring the doctor, and I refused to believe that she had ever been for him, and was persuaded that she too had entered into a conspiracy to poison me. She, however, protested that she had been, and that he would come soon. I again adjured her to go and bring him or some one from his house who would fetch me from that dreadful place. She again left the room, as did also the tall woman, and I was alone. I was in great mental distress, no help was forthcoming and I was in despair. I determined to jump out of the window and run home. With this intention I tried to make a rush at the window, but a great weight was pressing me down. After this I remember nothing until again disturbed by a cup held to my lips, and fluid running into my mouth, but I immediately spat it out. I was very exhausted and thought my end was now come; but clenched my teeth whenever the feeding cup was applied to my mouth, determined to resist to the very last, though I felt as if I could resist no longer, and must be poisoned. This ordeal was rendered doubly trying because all the time I craved for a cool drink, and dared not take it when offered as I was so firmly convinced of the woman's dark designs on my life. At last, when I was imagining myself just at the point of death, some one came from the doctor's to my great joy and relief. I felt safe again, and so ended this delusion.

[The tall woman no doubt represented the nurse, and the little one the landlady, though I did not recognize her at first. She afterwards told me how I sent her for the doctor, and accused herself and the nurse of wanting to poison me. So there can be no mistake, I think, about herself and the nurse representing the two attendants to whom I took such dislike, and who, I imagined had such murderous designs upon me. I had better mention here another event of that night, which occurred about 2 A. M. of the 11th day. I was found on the floor, unable to move, by the landlady, when she returned after my sending her the second time after the doctor. I had to be raised back on the bed. I remember nothing of this, but I believe it would be the finale of my attempted rush at the window.]

My next "wandering" was that I found myself in one of the London

hospitals. It seemed to me that I must have been sent there for better treatment; but how I got there was not obvious. I found myself in a bed in a draughty passage; was then removed into a cold, narrow, draughty room, where there were other beds occupied by patients. Any amount of tugging of the bed clothes closer round would not keep me warm. I was neglected there. I saw the nurse feeding the other patients; but she took no notice of me, and I did not like to ask her to come to me for fear of being thought troublesome. After a time she left the room; I was very thirsty, and there was no one to give me a drink, till after much rapping and shouting on my part, a *man* came to supply my wants. I then felt comforted, but made up my mind to leave that hospital in the morning, thinking I should be better looked after at home, and I remember no more about it.

On another occasion I was in bed at a station I did not know. This was in the daytime. I was to be taken somewhere by train. There was a crowd of people on the platform. My elder brother was with me, also a younger brother. After waiting a long time we unaccountably lost our train. We never could catch the right train; we got to the wrong platform, or if to the right platform it was too late, and so we kept moving from one to another for hours. I wished to get out of bed and dress myself, but my clothes could not be found, and this caused me great anxiety. This seems to be the first "wandering" I had in the *daytime*. All the foregoing delusions were retained in my memory; there were others which did not impress themselves so strongly on my mind. I now come to the "wandering" from which, to a very limited extent, I awoke to consciousness. I imagined myself transformed into two large beams of wood, fixed to each other at one end, and capable of being doubled up at their point of union. In this form I was situated in a deep, damp hole between two walls. At the bottom of this hole was some water. The beams were wet and had grown black from age and moisture. Water was also drop-drop-drop-ping down from the beams to the water below. In this position I did not feel in the least uncomfortable, only curious to know how I had become transformed into such an object. At this time I plainly saw the consultant, (Mr. Favell) standing at the foot of the bed. I thought he and Mr. Shaw were there at the same time; but I understand there was an interval of several hours between their visits; however, I realized the real presence of both. This was on the 19th day of illness. [I believe the notion of being always amongst water, which was so marked in the later wanderings, might be due to the fact that, at that time, the urine

was passed involuntarily, and the sensation of moisture next the skin probably gave rise to these delusions.]

I cannot give a regular chart of the temp., pulse and respiration. The whole course of the fever was characterized by restlessness and wakefulness, the eyes being wild and bloodshot. At the beginning of the second week, the temp. was 105° and pulse 120; they remained much about the same till the 16th day, when the former was 104° and the latter 114; and both gradually fell to normal, or nearly so, by the beginning of the fourth week. The bowels were, as a rule, confined; the only diarrhea occurred on the 17th day, and was of a moderate character. The capability of taking nourishment was retained throughout. The bodily weakness became very great in the first days of the third week. I appeared to answer questions correctly and talk rationally for the most part, so far, at least, as to lead those about me to believe that I was conscious. I was most impatient of any noises. Urine was passed voluntarily up to the 18th day, and involuntarily from that to the 21st. On the 18th day I was excessively restless, muttering delirium and subsultus tendinum, which were present during the previous few days, becoming very marked, and I was constantly picking at the bed clothes; but at 10 P. M. I fell asleep, and slept more or less soundly, and with but short intervals, for two nights and days, and from that time improvement set in.

On the 19th day it seems I was asleep when the consultant called; on his asking questions, I answered the first one or two, and said in a peevish tone, "I don't want to be bothered," and went to sleep again. I discovered my head to-day, but had no sensation of having any other members. On the 20th day, I found out my hands and fingers, and thought there was a large number of them. I also felt my abdomen, but was not sure if it belonged to me, and was constantly fumbling about it with my hands to see if I could make out that it really was mine; probably the distension of the bladder caused some uneasiness in that region, but I don't recollect feeling uncomfortable. The fingers felt numb, but I had no sensation at all in the abdomen any more than if I were handling a piece of wood. On the 21st day, I recognized the nurses about me. I remember now, for the first time, desiring to pass urine. The bladder was apparently partly paralyzed, as the water would not flow for some time, and straining was of no use; however, after waiting for a few minutes it came away, and I felt so comfortable afterwards. To-day, a college friend came from a distance to see me. I talked quite rationally with him, but remembered little of the conversation till he told me afterwards.

Convalescence having now set in, I progressed rapidly. I took what was offered, and had no desire but to lie as quiet and still as possible, and as long as I did so I had, for the most part, no unpleasant sensations of any kind, and no delirium. Up till Monday, the 23d day, I did not know where I was. As bowels were not moved for six days, it was decided to give an injection of turpentine, soap and warm water. The operation caused much pain and discomfort, and the injection brought away a free and copious motion, and left me much upset, so that the mind again became confused. I imagined several Irishmen were in bed with me, and that we were all huddled up one above another. I remained in this condition all the afternoon. Passed a good night and was much better this morning. Now began to feel hungry. I expect this sensation was increased by a quinine mixture I had been taking. They were unwilling to give me anything beside milk, beef tea, and champagne; but as I had grown rather tired of these I persuaded them to give me a lightly boiled egg, a little buttered bread, and a small cup of tea—all of which I relished exceedingly; but the tea seemed to distend the stomach with flatulence, and thus cause some discomfort. If I abstained from taking any tea there was no distension, and if I drank it to the extent of two mouthfuls, the distension and discomfort followed. On the 25th day, I had some oatmeal porridge and milk at 8 A. M.; this satisfied my hunger better than anything I had yet had, and was followed by no uncomfortable effects whatever. After two or three hours I had the eggs and buttered bread washed down by a mouthful of tea. In the afternoon I was able to sit up in bed propped by pillows. In the evening the mind again confused. This time I felt that I had several heads, but with a mental effort could realize that I had only one.

Now progressed rapidly and uninterruptedly, had porridge and milk every day for early breakfast, a lightly boiled egg with buttered bread, and as much tea as I dared take morning and evening. I drank considerable quantities of milk and beef tea, also a wineglassful of champagne, and a little port occasionally; but I did not relish these stimulants, and preferred to do without them. Yet I must say that, if I felt exhausted after being washed and sponged all over, a little champagne was most refreshing. During the fourth week there was some difficulty in passing water. This gradually disappeared. I was also troubled a little with noises in the ears—chiefly in the dark, and when I was left alone and there was no one else to take up my attention. I have already said that my eyes were weak, and during the fourth week black specs were constantly float-

ing before them. Since my return to consciousness the least movement caused me pain in the muscles brought into action. During the fourth and fifth weeks the abdomen was continually distended with flatulence, and the gases rumbled about more or less continuously. There was a painful spot on which I could lay the point of my forefinger at the region of the caput cecum coli. Pressure on this spot increased the pain, which was never acute and was localized to this one spot—it disappeared during the sixth week. This pain I laid to an ulcerated gland; its limitation and the absence of diarrhea lead me to believe that the glands generally were but slightly affected.

The bowels remained extremely costive, in spite of several compound rhubarb pills taken, I was very unwilling to have a second injection, but on the 30th day warm water simply was used; it served the purpose, and was accompanied or followed by no disagreeable effects whatever. A similar injection was given every day for a week; by that time I was able to leave my bed and move about, and the bowels then began to act regularly and spontaneously. During these early weeks of convalescence a curious fact I noticed was, that *when asleep on the right side I perspired very freely*. I could sleep best on the right side, and often when on the point of falling asleep I woke up again bathed in perspiration. I would then turn to the *left side and the perspiration ceased*. I don't pretend to explain this curious fact, which disappeared as I grew stronger. I was soon strong enough to walk round the room, and this enabled me to set my mind at rest concerning a delusion I had not altogether got rid of—I had a firm impression that some of my clothes had been stolen or lost. I felt particularly anxious about a handsome topcoat. I knew this idea was so ridiculous that if I enquired of any one I would be laughed at, and to avoid that I preferred to wait till able to ascertain for myself. Having to a limited extent recovered my walking powers gave me the opportunity of ascertaining, when I was pleased to find that the notion was only a delusion. On the 36th day I came down stairs; in a few more days went out and had short walks. After regaining consciousness I was still under the impression of being away from my old residence; after this was corrected it is curious that the impression on my mind of the house, and the street, too, being turned in the opposite direction from what they used to be, could not be got rid of to the day I left (a month afterwards). So much was this the case that when I walked out I would take the wrong direction to the main street, and only realise this after taking note of the surroundings. On March 8, seven weeks after the first definite symptoms,

I left Sheffield. For some months I was weaker and more easily tired than used to be the case, but I gradually grew more robust, till now (March, 1881) I feel as strong as ever.

Some lessons as to treatment.—I will not enter here at any length upon the treatment, but will confine myself chiefly to such lessons as my personal experience taught me. This experience has impressed upon my mind the necessity of quiet. There should be no tramping of feet nor loud talking—a harsh voice I found particularly unbearable, nor were musical sounds more tolerable. The room should be shaded from the light, for bright light hurts the eyes, and what irritates them stimulates the brain when it needs rest, thus the headache is not aggravated and sleep is not hindered. A more direct means of relieving the headache is the application of cold to the forehead; this gave me temporary relief. Cold water cloths, unless frequently repeated, soon lose their cold, so that if they are used, frequent changes should be attended. The ice-bag soon became useless and irritating. Instead of either I would recommend cold sponges dried so as not to allow the water to trickle down the face. While one sponge is on the forehead, the other can lie in the iced water, and the nurse should attend to their frequent interchange. A current of cold air blown across the face would be grateful too; this might be managed by an apparatus like the hand or foot spray, the air being made to pass through a chamber containing ice. Bromide potass. given internally might prove useful in allaying the headache and procuring sleep, but for this latter purpose hydrate of chloral is more effectual, and was given to me on the 15th night with apparently much benefit, both for the sleep and delirium. For pain in the back turpentine stupes are serviceable, but I should not hesitate, if the pain were severe, to use morphia subcutaneously with caution, watching its effect. Iced milk helped to allay my thirst, which was very pressing, and ice to suck was very grateful. During the whole course of illness, I took food well and generally as offered—from two to four pints of milk and from two to three pints of beef tea daily. From the beginning of the second week I had two and three wineglassfuls of champagne daily, by the end of the second week and during the third I sometimes had as much as half pint of champagne in 24 hours. During the 17th, 18th, and 19th days, I had altogether about 8 ounces of brandy, it was not given till there was evidence of much weakness. I doubt the expediency of giving so much champagne. In ordering stimulants to fever patients, I would be guided by Dr. Gairdner's dictum, that "Alcohol is not food but medicine." The nurse should

be strictly enjoined not to leave the patient for a moment. My own case would have ended fatally had I had strength enough to put my resolve into execution. In purposing to jump out of the window I had no suicidal notion whatever, my sole object being to escape from the disagreeable confinement in which I imagined myself detained. I also consider it important to humor the patient; nothing is to be gained by going ostentatiously contrary to his wishes—it will only confirm him in his delusion. I believe it is desirable to have the body-heat lowered if it can be done without interfering with the digestive and assimilative powers, or otherwise with the comfort of patient, but it is doubtful whether a high temp. is more dangerous to life than the unpleasant symptoms which are apt to follow the administration of drugs for lowering it. The “cold bath” seems to me to be too formidable, but a modification of it in the form of cloths, wrung out of iced water, applied to the abdomen, and often repeated till the temperature recedes to 100° , as I have seen done in the wards of Dr. M’Call Anderson, is a much more practicable method, and one I would not hesitate to employ. For correcting torpid bowels, I believe injections of warm water will prove effectual in most cases, and are preferable to aperients given by the month. I would be loth to use turpentine in injections, on account of its severe effects. During convalescence excesses of all kind—mental, physical and dietetic—should be avoided, and it must be remembered that very little may be “excess” at first. I believe singeing the hair every ten days or so, for some months, to be the best means for promoting its growth. For disinfecting purposes Condry’s fluid was used in my case—all the excreta were well mixed with it, emptied immediately, and some of it put into the washed utensils, and the floor well sprinkled every morning. Of ten persons who came into more or less direct contact with me during most of the time I was ill none took the fever.

Conclusion.—On March 8, 1880, I weighed 9 st. $4\frac{1}{2}$ lbs.—this was seven weeks after the first definite symptoms. On March 8, 1881, I weighed 10 st. $7\frac{1}{2}$ lbs.—an increase of 17 lbs. in 12 months. Before the fever I never weighed above 10 st., so that, taking the increase in my weight along with the fact that I was never in better health than at the present, I gather that typhoid fever may leave the system, though temporarily debilitated, not permanently so, and with the digestive and assimilative powers more active than before, and mental energy in no way abated.

I shall close this history with the following deductions—viz., in typhoid

fever: 1. The disease may begin and advance, at first, very insidiously. 2. The brain may be more affected than the bowels. 3. Patients, while really unconscious, may simulate consciousness so far as to deceive bystanders. 4. Delirious patients, apparently bent on self-destruction, and such as are untimely killed by a rash act, are not necessarily impelled by suicidal motives. 5. Delirium is of a restless and distressing character. 6. False impressions received during delirium may be retained after recovery of consciousness. 7. After a severe attack no bad sequelæ need follow; the general health may improve, and the mind, even after prolonged unconsciousness and evidence of great disturbance, may regain its usual powers. 8. Typhoid fever is not really communicable from one person to another.—*Glasgow Med. Jour.*, Aug., 1881.

*TREATMENT OF CHRONIC CYSTITIS WITH THE AID
OF A CURETTE FOR SCRAPING THE SURFACE
OF THE BLADDER DESIGNED FOR
THE PURPOSE.*

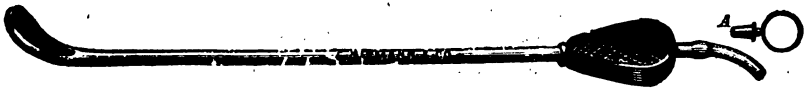
BY W. H. MUSSEY, M. D., CINCINNATI, OHIO.

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Read before the Ohio State Medical Society.

In a case of lithotripsy I was unable to cleanse the bladder of the *debris*, owing to the softness of the stone and the entanglement of fragments in the mucous surface of the bladder, and the blood clots that were present.

At the second sitting I was prepared with a curette that I had had constructed for the occasion. I gradually dilated the urethra with a bougie



till I could pass easily this instrument that I now exhibit to you, a No. 20 (American scale) solid steel sound, which, as you perceive, has a *very long* curve in contrast with the so-called "Van Buren curve," which is short and abrupt. This long curve, of all that I have used, is the best adapted to the neck of the bladder in such cases; indeed, in cases of enlarged prostate, and in persons of middle life, I prefer it to all others.

After the dilatation I used the curette to thoroughly scrape the surface of the bladder and remove much of the scrapings; then with a large silver

catheter I cleaned the viscus thoroughly by irrigation, and the patient had a good recovery.

In a second case, where I suspected stone, and the sounding resulted negatively, I dilated to size of bougie, *No. 20*, scraped the surface with the curette, and brought out a quantity of muco-purulent accumulation and clots of blood; then, with irrigation, cleansed the bladder and had a complete success.

A third case, with similar details of condition and practice, was followed by like results.

In the pursuance of this treatment it is important to evacuate the bladder twice a day with the soft rubber catheter.

As a wash for the bladder, I use an emulsion of gum benzoin, one ounce in one pint of water, which should be boiled six (6) hours and filled to one pint. In some cases I add to the emulsion carbolic acid, or boracic acid, in varying proportions.

Constitutional indications are not to be disregarded.

The curette scoop is *No. 18*, and the shaft, which is a canula, with a stop-cock at the opposite extremity, is *No. 14*, to which a drainage tube may be attached.

I have requested Messrs Tiemann & Co., New York, who made the first instruments, to construct one with a double canula.

PHYSICIANS AS STUDENTS.

BY J. N. BEECH, M. D., WEST JEFFERSON, OHIO.

President's Address before the Central Ohio Medical Society.

Gentlemen: The "Common Law" of Medical Societies requires of me an address on some subject pertaining to medicine. There can be no more thread-bare subject than Medical Education, but believing there may yet be something said, I have selected it for the paper to-day. In doing this I do not propose going over the old ground so often travelled by essayists, who have clamored for better preliminary education for students, and a higher standard of graduation by the colleges. These features of the question of a higher and better preparation for the practice of our profession have been thoroughly discussed, until nothing new can be said, and I believe that this continued agitation has resulted in great good. There can be no doubt but that the students of to-day are much better qualified by previous mental training to enter upon the study of medicine than they were thirty years ago, or that the requirements for graduation

are more stringent now than then. The plea I make to-day is for a better and higher education of the profession than can be obtained in the usual three years' course of study. The necessity of this is so apparent that it may seem absurd to say one word, or to make an argument in favor of a proposition that all will concede, and yet a little consideration of this matter may not be time lost.

Medicine, to-day, is the result of experiment, of thought, stumbling along through the mists of ages, now emerging from the gloom, and again being shrouded for centuries, to appear again as some great thinker develops new theories or new facts, always getting more and more into the light, until now it stands a beautiful monument, speaking of the thought, careful observation, and patient research of thousands of toilers in our profession. The student of to-day, having the advantage of the collected and arranged thought of thousands of years, can accomplish much in three years of study. He can know more of Anatomy than Harvey, more of Surgery than Ambrose Pare, more of Obstetrics and its kindred science, Gynecology, than Ramsbotham, and so on through the list of studies that make up his college course; why, then, should he not be content? Why should we insist upon further continuous study? As most of my hearers are gentlemen whose diplomas were dated many years ago, I leave the answer to them. Have we made the best use of our time since our pupilage? Have we striven for the excellence in our profession that each one now, with the light of experience, believes was obtainable? Have we reached that position in the profession, that confidence in our own ability, that is born of work and study, that we should have, and have we the confidence of our patrons that we should deserve?

Let us glance for a moment at the usual course of students after graduation. Of every hundred, a small per cent., blessed with means, will go abroad and continue their studies, or enter some of the hospitals of our own country, where there are large clinical facilities, or devote a few years to the study of some specialty, and a large proportion of these, with such advantages, will take leading positions in the profession. A majority of graduates, however, go direct from the college into practice. Their means will not admit of a longer pupilage, and they must enter at once upon the practice of their chosen profession to keep the wolf from the door. If such necessity prevented further study the future of such men would be deplorable indeed. They would, at best, be mere money-making machines. As it is, it is bad enough. The student enters upon practice, and just at the time when he most needs to study, to think, and

to observe, he most neglects all these. Social matters take up his time, as through these he expects to gain patrons; he is more interested in making acquaintances than in prosecuting his studies, and the weak side of human nature in his neighborhood seems to him a problem of far more importance than any found in books. If the young man have a good address, tact and push, all these will meet with reward, and he will soon have a practice, will make money, and, with less and less inclination to study, will soon dabble in politics, or engage in merchandising, farming, or something equally foreign to his profession. Who will say that this is an overdrawn picture of the ordinarily successful practitioner? Successful in getting patients, successful in making money, successful in getting social position, what more need he want? If these are the chief aim of the profession, nothing more. If we do not care for a consciousness of entire preparation, the result of continued devotion to our profession, to meet with the difficulties that are springing up in our path every day, then we might be content to drift along in this mentally lazy way, satisfied with perhaps an abundance of fees that we have not deserved. But such physicians will find, as they grow older, that they are not equal to emergencies, that, in fact, they are not fairly entitled to the patronage they receive, and now and then they will discover that the public does not regard them as safe advisers. Are there no members of this society who have not at some time felt humiliation attending the discovery that a much esteemed patron has not regarded their qualifications as entitling them to treat his family in anything but the most ordinary ailments? The sting of this discovery is all the more severe from a self-knowledge that the want of confidence is deserved; that there has been nothing in our daily life to impress our neighbors with an idea of any more than ordinary ability and skill on our part. As illustrative of the feeling of the public for this grade of physicians, a friend complained to me a short time since that one of his long time friends had gone to Columbus for treatment for some difficulty of the head. It was no consolation to the doctor that his patron assured him that he "esteemed him highly, but in his own case he thought he had better go where he could consult a regular brain doctor." Here was a want of confidence in his family physician, a man whom he loved and believed in in everything else, only that he lacked at least more than ordinary skill. Every village in Ohio furnishes similar examples of want of confidence in their home physicians, and I am sorry to say in a majority of the cases the public have accurately measured the calibre of their physicians, and are right in withholding their patronage. But need this be?

Need our patrons be running off to the city after brain doctors, womb doctors, eye doctors, bone doctors, etc.? Why should we be robbed of reasonable fees, and our patrons subjected to the onerous expenses attending the treatment of a specialist in a distant city? Is this the fault of the public always? I think not. Our lack of preparation is so often apparent that our patrons cannot afford to leave what they regard as serious cases in our hands, and they very properly go where there is a reputation for superior skill.

What I ask for is a preparation on the part of every physician that will give him confidence in himself and engage the confidence of the public. To do this, money is not required; if it were, few of us would ever become physicians except in name. A post graduate course at a college, or service in hospitals, however advantageous, is not absolutely essential to success; the leisure that every physician has in the first few years of his practice, may be utilized to nearly as much advantage as though he was giving his whole time to study. What hinders any member of this society from being as thoroughly familiar with the steps necessary in the reduction of dislocation of the hip or shoulder joint, or the replacement of hernia, or an operation for the same, or the amputation of a limb, or many of the less difficult operations in surgery, as are the surgeons of Columbus? Why should not A, country practitioner though he is, be as capable of using the laryngoscope as B, or the ophthalmoscope as C, or the microscope as D? With the same experience, why should one man be better qualified to examine the uterus intelligently, to apply a tampon correctly, or the forceps more skilfully, than another?

While I claim for each member of the profession the right to know as much as any other member, and to be as well qualified to treat all the diseases as another, and that it is not only his privilege but his duty to be thus qualified, I do not forget that a certain proportion of the profession will always fall back upon gentlemen whose tastes, opportunities and untiring study have given them the justly deserved confidence of the profession as well as the public. Not every qualified physician has any taste for the practice of surgery, and gladly transfers that part of his business to the surgeon, and we all, at times, feel the need of the superior skill of the specialist. But while we acknowledge this superior skill it does not lessen our obligation to ourselves, and to our patrons, to as thoroughly qualify ourselves for every emergency, as though we had no specialists.

Assuming then, that there is a lack of this careful preparation, and that there is an obligation for us to give to our patrons the benefit of the best

skill attainable, how are we to seek for it? How are we to reach the end aimed at? The answer is so apparent to all that I scarcely need say that we should always be students. If this involved the continued expenditure of money for teachers, the mass of the profession would necessarily remain with only the rudiments of a medical education, but, fortunately, superiority in the profession is denied to no one who is willing to labor for it. Graduation only implies a certain amount of routine knowledge, which, if not followed up by continuous study, only fits a man for routine practice, and that in the most ordinary diseases. The text books of the colleges should be supplemented by the study of other works on the same subjects; the leisure of the practitioner should be given to his books as fully as before graduation. The use of the laryngoscope, ophthalmoscope, and microscope can be learned in such leisure hours as well as with teachers. If our leisure is thus occupied good results will surely follow. This is not simply theory; we have examples of such success in almost every county. There are gentlemen in this city, whom all acknowledge as having reached an enviable position in the profession, and whose success has not been accidental, or in consequence of superior advantages, but simply because they have always been students, and are closer students now, when success might well afford them an excuse for relaxation, than they were at the start. They have succeeded because they have been devoted to their profession, have never had leisure for amusements, or politics, or speculations, or loafing.

But while the study of books is important, is a necessity, it is not all. Books tell us what others know, but he who acts upon his book-knowledge alone will make a poor physician. Physiology, healthy life, may be studied outside of books; we may see its manifestations every hour, and may thus get a standard of healthy life, with which to compare disease. The cultivation of our special senses should not be neglected. The possession of a cultivated eye, ear, and touch seems to me to mark the distinction between physicians more than their comparative standing in their classes at college. What may not the eye, when trained to see aright, show us. The appearance of the skin, tongue, countenance, position in bed, are of supreme importance, and yet how much more quickly are they seen and their significance estimated by one physician than another. With the ear applied to the chest, one physician will understand his case, while another, with an untrained ear, can have but a confused idea of what the sounds indicate. The cry of the sick child, to one physician, speaks volumes as to the nature and locality of the disease, while to

another, it is a child's cry and nothing more; and yet the child's cry, its motions, its countenance, speak much more intelligently to us than the mother or nurse.

In conclusion, let me say that to be successful in our profession we must be devoted to it, honor it, speak well of it, love it. If we do this and do not degrade it by sordid aims, if we do not dishonor it by the tricks of the charlatan, nor dethrone it from an intellectual pursuit and benevolent calling, and make it simply one of the inferior trades of life, men will not only honor and respect us, but will give us that generous support that we deserve. While then we should thus strive for excellence in our profession, that we may practice it with safety to our patient, with satisfaction to our own minds, and with honor to our profession, we may do so with the assurance that no other course is so likely to secure to us what we all desire—social position, influence in community, and, finally, the financial reward that our labor in preparation, and devotion to our profession fairly entitle us to.

CASES OF HEREDITARY SYPHILIS.

BY WEBB J. KELLY, M. D., INDIANAPOLIS, IND.

Case I.—Twins; females; aged two weeks; farmer's children; one with "syphilitic roseola," and the other with "pustulo-crustaceous syphilis;" both good recoveries.

Parents' History.—Mother.—Black eyes and hair; aged about forty-five years; nativity, German; mother of seven children. No history of syphilis. Has never had any eruption. Has never miscarried. Father—Dark hair and eyes; aged forty-eight years; nativity, German. During the late war he contracted a chancre. The surgeon in charge cauterized it, after which it healed up without further trouble. He says there was no subsequent eruption, and that he did not take any constitutional treatment. About 1879 he commenced suffering from an ulcerative sore throat, which his physician was unable to heal. In connection with his sore throat, he had, if his statement can be relied upon, a goodly crop of pustules covering the upper part of his body. In 1871 or '72, he came under the professional care of my esteemed father and preceptor, Dr. H. R. Kelly, of Galion, Ohio, who put him through a regular course of anti-syphilitic treatment, which had the effect of causing the disappearance of all outward signs of the disease. No reappearance of the disease up to the date of the birth of the twins.

II.—3.—3.

Patients' History.—When the children were born they appeared perfectly healthy, being about the size of ordinary twins. About two weeks after their birth, while attending a case of pneumonia in the same family, the mother called my attention to a "breaking out on the twins." Upon examination I found one of them pretty well covered on the arms, neck, face and forehead with syphilitic roseola, and the other had several angry looking pustulo-crustaceous syphilides upon its face and about the angles of the jaw. For the latter I ordered mutton suet dressings. Prescribed minute powders of hydrarg. cum creta, combined with bismuth, to be given four times a day in a little milk. In two weeks the roseola had faded away; and, in the other case, the ulcers were almost gone. This treatment was continued, with occasional intermissions, for quite a long time after all outward signs of the disease had disappeared. They have never shown any signs of the disease since, and they are now almost three years old.

Case II.—John S—; aged twelve years; light complexion; strong, active farmer boy; always been healthy; brother of the twins in case I. Ulcerative syphilis of the fauces; good recovery.

Came to me to be treated for sore throat at the time the twins were about three months old. He had been troubled with a dryness of the throat for some time (before the birth of the twins). During the day it did not trouble him very much, but at night he suffered very much from the dryness and tickling sensation. He always had a glass of water by the bedside, from which he would take a swallow several times during the night. Of late he had been feeling very much as if he would have an ague chill every day. He complained of an aching of the bones of his lower extremities at night, the tibias being the worst.

Examination revealed a clear-cut syphilitic ulcer just in front of the uvula, and several small irregular ulcers on the sides of the fauces. Touched the ulcers with pure nitric acid, and placed him under active anti-syphilitic treatment, having him take one-eighth of a grain of protoiodide of mercury every five hours, and increased the dose one-eighth of a grain every day until he became pretty thoroughly mercurialized. I then gave him my favorite prescription for syphilis: Potas. iod., $\mathfrak{zss}$: hydrarg. chlor. corros., gr. iss; comp. syr. sarsap., $\mathfrak{ziv}$. *M. Sig.*—Teaspoonful four times a day. He continued this treatment for four months, and has had no recurrence of the disease, nor do I think he ever will have. This was a very interesting case, as there is no doubt but what it was hereditary, and had lain dormant in his system twelve years. An-

other feature of the case was; that when the conception took place there were no symptoms of the disease in the father, nor were there any until almost one year and a half afterwards, when he showed the secondary symptoms for the first time. It is very rare to see a case of hereditary syphilis where the conception took place before any secondary symptoms had shown themselves on the parent. Had I not known the previous history of the parents so well, I would not have believed it.

Case III.—F—— S——; female; aged five years; light complexion; very delicate; hereditary syphilis; fair recovery.

Parents' History.—About twelve years ago the father, who is a railroad engineer, contracted syphilis in the usual way. The chancre was healed up, but no constitutional treatment was given. In about eighteen months the secondary symptoms made their appearance in the form of roseola. This was quickly followed by the tertiary stage. He then commenced taking constitutional treatment, not, however, until his wife had become infected with the disease. As soon as his throat became a little better, he stopped taking treatment, and has only taken it for a short period at a time since; in fact, only when he feels the effects of the disease. His wife is the same way. Neither of them has taken continuous treatment long enough to eradicate the disease. The mother has had four miscarriages, the fetus in every instance showing the effects of the constitutional disease in the parents. When the mother found she was pregnant for the fifth time, she was very anxious to have a living child. She sought advice and at the second month was placed under the mixed treatment, which was continued up to the eighth month, when the child was born alive. It was completely covered with the characteristic copper-colored blotches, with here and there a pustule, but by fairly feeding the little thing on mercury it gradually improved, and at the end of nine months or a year it was entirely free from any signs of the disease. Her forehead still bears evidence of her having had the disease by the peculiar little pox-marks remaining as a token of its sincerity. She never had any further difficulty until last summer, at which time I was called to see her, and found the following symptoms: Skin almost yellow; eyes dull; tongue heavily coated; bowels constipated; urine dark, scanty and having a bad odor; high fever; liver enlarged; tenderness over kidneys; temperature 102° to 103° . I gave her a purgative, infusion digitalis and acetate of potash, quinine and tinct. verat. viride. This did no good. I then gave her calomel and continued the infusion digitalis and potash. It was surpris-

ing how rapidly the symptoms changed. The secretions became normal and the fever fell. In a few days she was around the house playing. I then placed her under anti-syphilitic treatment, and continued it for some three months. She had improved very much in flesh, and in every way. I think, without doubt, the bilious attack was brought on by the syphilis in her system.

Case IV.—Eddie —; aged five months; illegitimate; pale, puny, scraggy child. The mother of this child, a prostitute, has had syphilis, and is now suffering from it. She says the father of the child was never infected with the disease, nor do I think he ever was, as examination fails to reveal any signs of it. The child was brought to me about six weeks ago, to be treated for “cholera infantum.” It was having from eighteen to twenty bloody mucous stools in twenty-four hours, and was suffering from all the symptoms of the disease. In examining him I noticed his body was pretty well covered with a roseola, and further examination showed that his mouth was one mass of ulcers. His mother stated that he was born that way, and was getting worse all the time. Thinking the child would die anyway, I thought to try anti-syphilitic treatment, instead of endeavoring to check the bowels. I gave pretty good sized doses of mercury and chalk, combined with bismuth, every four hours. At the end of the fourth day his bowels had become so much better that he had only two stools in twenty-four hours. Ordered the mother to take him away from the breast and to give him cow’s milk. Continued the mercury for about two weeks, when I changed to the syr. iodide of iron. He will take this until his strength has recovered sufficiently, when I will again give him mercury. I had the mother swab out his mouth, morning and evening, with a solution of sulphate of copper, ten grains to the ounce. At the time of this writing, six weeks from the time I first saw him, the roseola is nearly all gone, and the ulcers in his mouth are all healed. I think with careful nursing and good rich milk he will finally come out all right.

I give these few cases of hereditary syphilis for the reason that the parents’ history in every case is well known. In the first and second, only the father had the disease; in the third, both parents; and in the fourth, the mother alone was infected. In quite a syphilitic practice, I have observed two things which have been very much impressed on my mind, *i. e.*: 1st. It is very rare for a child, conceived of a father who has *primary* syphilis to show any signs of the disease. 2d. When the mother has the disease it always shows, as a rule, sooner on the child

than when the father alone has it. When the father has it and the mother has not, it is very seldom that she will miscarry.

In the treatment of very young children, I have found nothing so beneficial as mercury, chalk and bismuth. This will thoroughly control the disease when nothing else will have an effect.

In concluding this report, I would like to give it as my opinion, that when either parent has had "constitutional syphilis," no difference how long they may take treatment, nor how well they feel, they cannot have children that will not, sometime or other, show the effects of the disease.

PECULIAR FEATURES OF PNEUMONIA IN YOUNG CHILDREN—FROM A CLINICAL LECTURE.

BY W. J. CONKLIN, M. D., OF DAYTON, OHIO.

Professor of Diseases of Children in Starling Medical College.

In children, as in adults, we meet with two forms of acute pneumonia, but the comparative frequency with which they occur, varies greatly at the different periods of life. Lobar or croupous pneumonia is preeminently a disease of adult life, while the lobular or catarrhal form is peculiarly the pneumonia of infancy. In a child under five years of age the presumption is strongly in favor of the catarrhal form, but I am positive that lobar pneumonia is by no means so unfrequent, even in infancy, as many authorities would lead us to infer. As you know, it is not very unusual to meet even nurslings in our dispensary practice suffering from lobar pneumonia.

Squire, of London, reports several cases which came under his observation; Steinits gives the histories of eighty-four cases which occurred in his clinic at Breslau; and Ziemssen records one hundred and eighty-six cases, of which one hundred and seventeen occurred in the first six years, and sixty-nine in the succeeding ten years of life. Juergensen, after alluding to the difficulties of diagnosis in children, makes the statement that many who are reported to have died from "teething," "worms," "convulsions," etc., have really succumbed to an unrecognized lobar pneumonia.

Lobular pneumonia is in fact a capillary bronchitis plus an affection of the air cells, and is happily named broncho-pneumonia. It never occurs as a primary lesion, but is always secondary to a bronchitis or to those specific diseases, as measles and pertussis, in which bronchial catarrh is a

part of the natural history. It is also intimately associated with certain diatheses, as rickets and scrofula.

The conditions which render a bronchitis so much more serious in early than in adult life, largely hinge upon the smaller sizes of the bronchioles. To reduce the calibre of a bronchus in an adult by its thickened mucosa and the adhesion to its walls of tough mucus, will only slightly interfere with its function as a carrier of air, but in the smaller tube of the child it means occlusion more or less complete, with resultant dyspnea, lobular collapse, and perhaps pneumonic infiltration.

Collapse of the lobules of the lung, which is such a common complication of bronchitis in children, plays an important role in the development of catarrhal pneumonia. Many authorities hold it to be absolutely essential that collapse of one or more pulmonary lobules should precede the inflammation of the alveoli. In this event the links of the chain are bronchitis, plugging of a bronchus by swollen membrane and mucus, collapse of lobule, and, finally, the setting up in the collapsed portion of an inflammatory process similar to, but not identical with, that of croupous pneumonia. Others, while admitting that this is the usual sequence, maintain that the collapse is not essential, and that the inflammation often travels along the successive branches of the bronchial tree, and thus invades the air-cells. The balance of proof is, undoubtedly, in favor of the view that pulmonary collapse is the very frequent, but not necessary, antecedent of the pneumonia.

It is estimated that one-sixth of the illnesses, and about the same proportion of deaths in children under five years of age, are due to catarrhal diseases of the respiratory organs. But lobular pneumonia possesses intense clinical interest, not only on account of its fatality, but also for the reason that it is recognized as the chief factor in the etiology of caseous phthisis. Under favorable circumstances, the epithelial cells and leucocytes which crowd the bronchioles, alveoli and intervening connective tissue, undergo a conversion into fat and are absorbed, or into mucus and expectorated. But if anything occurs to arrest these processes; if the constitution be vulnerable from inheritance, previous disease, or bad surroundings, the inflammatory product becomes converted into a caseous mass, which mechanically compresses air-cells, bronchioles, and blood-vessels until they die, and then the child has so-called caseous phthisis. Again, acute miliary tuberculosis—tubercular phthisis—is by no means an infrequent sequel of a catarrhal pneumonia.

You are already familiar with the clinical portraits of both forms of

pneumonia, and I pass at once to the consideration of some of the more important differences between the pneumonias of early and later life.

1. As to the portion of lung involved in the disease. In an adult a croupous pneumonia is very generally limited to the lower lobe of the right lung, but in children it attacks indifferently either lung or any lobe. In a fair proportion of cases the upper and middle lobes are affected, with or without implication of the base. Nurslings or feeble children of any age are especially apt to suffer from an apex pneumonia, but it is by no means uncommon in the robust, as in the case before us this afternoon. In fifty-one cases recorded by Meigs and Pepper, the upper lobe was affected in twenty, while in thirty-one the base of the lung was the seat of the disease.

In the catarrhal form of the disease, which is generally bilateral, there also exists in children a greater proneness to implication of the upper lobes than in adults. It is, therefore, an invaluable practical rule, if you would avoid falling into error, to carefully interrogate the apex as well as the base of the chest when a child is ill with a suspected lung trouble of any kind.

A pneumonia limited to the upper lobe would, in the adult, be open to the gravest suspicion; indeed, it would very positively indicate the presence of a tubercular deposit or a specially vulnerable constitution. In the young, however, it is not unusual to find the apex involved, without any suggestion in the family record or previous history of a tubercular diathesis, and occasionally the inflammation will run its course without anything phenomenal in the symptoms or termination. But it is important for you to remember the clinical fact that, as a rule, an apex pneumonia, be it lobar or lobular, does not run the typical course with which you are so familiar. The inflammatory product is more slowly deposited and more slowly removed, the febrile movement and nervous symptoms are out of proportion to the amount of lung involved, and the whole attack wears a graver physiognomy. This fact will occasionally render your diagnosis very doubtful. Physical signs can only tell the presence, not the nature of the consolidation. I am satisfied that in many cases it will be impossible to decide until sufficient time has elapsed whether a given solidification of the apex is due to acute tuberculosis or to a slow resolving pneumonia. Usually, however, the history of the attack, the child's inheritance, the condition of the lymphatic glands, the extent of the solidification, and the thermometric range will guide us to the truth. Ziemssen was the first to point out that in lobar pneumonia,

even of the apex, the thermometer registers a higher degree, and shows less fluctuation between morning and evening temperatures than in consolidation from tubercular deposit.

The difficulties are greater when the differentiation must be made in the lobular disease. Dr. Buchanan makes the statement in his Lettsomian Lectures that, "For anything that can be made out by the stethoscope, the thermometer, or the most careful clinical inquiry, it is absolutely impossible to say whether the lung signs are due to acute tuberculization or to lobular pneumonia."

2. As to the import and frequency of some of the symptoms. The chill which so frequently ushers in a pneumonia in an adult is rarely met with in the child, and if present only amounts to a sensation of chilliness. The nervous symptoms are much more pronounced in the child than in the adult. Very often a pneumonia, especially of the lobar form, is announced by a convulsion, and these cases are not necessarily marked by other cerebral disturbances, or do not always foretell the graver forms. The excitable nervous organizations of children render them peculiarly liable to these "nerve storms." In many cases, with or without the initial convulsion, the nervous symptoms assume such prominence as to distract attention from the real seat of disease. Headache, vomiting, delirium, stupor, and convulsions, constitute a grouping of symptoms which will easily mislead a careless practitioner. It is important to bear in mind that cerebral symptoms are apt to predominate when the upper lobe is involved. While the rule is not absolute, an apex pneumonia rarely runs its course without the presence of more or less decided brain symptoms, and, for this reason, many authors designate this form as cerebral pneumonia. This peculiarity is well exemplified in the case before us—the initial convulsion, the stupor, the boring of the occiput into the pillow, and the muscular twitching are quite characteristic. A knowledge of the manner in which pneumonia may simulate a meningitis will be enough to put you on your guard. Occasionally you will be compelled to withhold, for a time, your diagnosis, but usually a careful exploration of the chest will lead to a correct interpretation of the symptoms.

The sputum does not possess the same diagnostic characters in the child as in the adult. Under five or six years of age, children rarely expectorate. Unless taught by the hard experience of a whooping-cough, or chronic bronchitis, the sputum is coughed into the fauces and swallowed. When present it is not rusty and viscid, even in lobar pneumonia, but is light in

color, thin, frothy and less tenacious. In the catarrhal form, as you know, the extruded matter is not an exudation from the blood, but is the product of cell proliferation commingled with the secretion of the mucous glands. Exudation of red blood-corpuscles rarely occurs in catarrhal inflammations, and as these form so large a proportion of infantile pneumonias, the absence of rusty sputa is easily explained.

Children with relatively the same amount of lung involved ordinarily suffer greater dyspnea than adults. This is seen in the rapid breathing, the action of the auxiliary respiratory muscles, and infra-mammary retraction of the thoracic walls, which attend upon comparatively mild grades of the disease. In a case of moderate severity the breathing rises as high as forty or fifty respirations per minute, while in the graver forms they may number eighty or ninety, and the pulse respiration ratio will be correspondingly altered. Not infrequently, the rhythm of the respiratory acts is so changed that the pause comes after the inspiration instead of after the expiration.

There are three symptoms which possess much greater diagnostic value in the child than in the adult—the respiratory moan, the flapping of the nares, and the sulcus around the base of the chest. The latter tells unmistakably of the impeded entrance to air, and is usually indicative of capillary bronchitis, lobular pneumonia, or laryngeal stenosis. Although the expiratory moan is not, as it was formerly considered, pathognomonic of intra-thoracic disease, it does indicate, with tolerable correctness, a pleurisy or lobar pneumonia.

Another striking peculiarity of infantile pneumonias is the insidious manner in which they are frequently developed. We have already spoken of the closeness with which lobar pneumonia may simulate simple meningitis, and might, with equal propriety, draw attention to the similarity which often exists between chronic lobular pneumonia and tubercular meningitis. As thorough a clinician as Juergensen states that it is often impossible to determine with certainty whether a child suffering from catarrhal pneumonia has not at the same time a moderate crop of tubercles in the brain.

A sub-acute pneumonia not infrequently creeps on during the progress of an acute illness, especially an entero-colitis, and presents but few symptoms to indicate the dangerous complication.

Badly nourished, especially bottle-fed, babies will, without any acute disease, frequently suffer from passive congestion of the lungs or lobular collapse, due to the feebleness of the respiratory and circulatory move-

ments, which will result in a form of catarrhal inflammation—hypostatic pneumonia—and yet be announced by very indefinite pulmonary symptoms.

An important therapeutic hint can be drawn from these facts. When a feeble or young infant is seriously ill with any acute disease, it is of great advantage to insist on frequent changes of position, and even allowing it, at intervals, to rest upon its abdomen so as to obviate this tendency to hypostatic congestion.

3. As to physical signs.

Pneumonia in the child is recognized by the same physical signs as in the adult, and yet there are some important modifications, which, if ignored, will inevitably lead to mistaken diagnosis. It may, perhaps, be unnecessary to refresh your memories as to the peculiarities of the normal breathing of young children.

You know that in the forced breathing of infants, or in the ordinary respiration of those over two years of age, the normal vesicular murmur has a blowing or bronchial character, to which the name “puerile” was given by Laennec. Therefore, breathing sounds, which are normal in the infant, would, in the adult, signify morbid changes in the parenchyma of the lung.

Percussion in the child normally elicits a more sonorous sound than in the adult, on account of the thinness of the chest walls, the smaller bulk of the lungs, and the ease with which the air in the primary bronchi and trachea is thrown into vibration.

Another point of undoubted clinical importance is that there is often a normal difference in the resonance of the apices of the child's chest, the opposite of that found in the adult. Dr. Buchanan has shown that, in healthy children under seven years of age, the left apex is quite commonly a little duller than the right.

Beyond doubt many practitioners are constantly misled by failing to appreciate the extent to which tension of the abdominal muscles may modify the results of physical exploration of the chest. The moment you attempt to percuss a child, it voluntarily or involuntarily, employs what Vogel terms “abdominal pressure,” whereby the abdominal viscera are forced upwards and encroach upon the thoracic cavity: on this account the line of dullness is different on opposite sides and is constantly changing on the same side of the thorax.

The liver, which is relatively very large in the child, may in this way cause dullness up to the spine of the scapula. To eliminate error from

this source, it is essential that you continue your examination in one spot long enough to percuss at the moment of the deepest inspiration and the most complete expiration.

The crepitant rale—that fine, sharp crepitation which is almost pathognomonic of pneumonia in the adult, is rarely heard in children under three or five years of age; and when heard it is a louder, coarser, moister rale, resembling in character crepitation *redux* or a fine *subcrepitant* rale.

Vocal fremitus, which has such diagnostic value in the adult, is less trustworthy in the child. Very often it is absent from both sides of the chest, and sometimes seems to be more marked upon the sound than upon the diseased side. When it is found *only* on the *diseased side* it, of course, becomes a valuable indication of solidified lung. The physical signs of consolidation are, as a rule, however, sufficiently marked in a croupous pneumonia affecting the youngest child to enable you with proper care to reach a correct diagnosis. But in the catarrhal form the physical signs are less distinct, excepting as they reveal the ever-present bronchitis, and upon them *alone* it would often be impossible to build up a diagnosis. The nature of lobular pneumonia offers a ready explanation of this fact. In the common form of the disease, the lung is studded with pneumonic patches, varying in size from a pea to a filbert, each consisting of one or more lobules separated from each other by a network of healthy crepitating lung tissue. If, as often happens, several contiguous lobules are involved so as to cause consolidation of a considerable area, the physical signs are very pronounced and unmistakable. Physical exploration alone will, only in exceptional cases, enable you decide whether the solidification in a given case is due to simple collapse of lobules in the course of a capillary bronchitis or to pneumonic patches. The exceptional cases are when the signs fluctuate under examination or within short periods; for instance, dullness, and bronchial respiration, which would disappear after severe coughing, would positively indicate collapse. The diagnosis of the lobular pneumonia must therefore be largely made from the history and symptoms, reinforced or not by the physical evidences of consolidation.

If, in the course of a simple bronchitis, the fever is suddenly increased, the cough becomes hacking and painful, the breathing more labored and the pulse-respiration ratio altered, the accession of a catarrhal pneumonia is very often certain, and if now, in addition to the ordinary bronchial rales, you can detect localized dullness, tubular breathing, and other signs of solidification, the chain of evidence is complete.

Catarrhal pneumonia is usually a bilateral disease, and a characteristic form for the solidified portion to take is that of a pyramidal strip extending two or three inches along each side of the spine, resembling in these respects simple lobular collapse. The thermometer renders invaluable aid in differentiating between capillary bronchitis and its sequelæ, catarrhal pneumonia and lobular collapse.

Capillary bronchitis is normally attended with only moderate febrile movement, the mercury fluctuating between 102° and 103° F. A sudden exacerbation of fever in the course of a bronchial catarrh, in which the thermometer registers 104° F., or higher, strongly suggests the onset of a pneumonia, while a sudden and marked fall of the mercury without a corresponding improvement in other symptoms points to lobular collapse.

There are other peculiarities to which attention might be called, but we have probably said enough to convince you that infantile pneumonias are worthy of your earnest and conscientious study.—*Phil. Med. News.*

CYST OF THE FRONTAL SINUS.

TRANSLATED BY HENRY G. CORNWELL, M. D., COLUMBUS, OHIO,

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Most writers on ophthalmology mention the frontal sinuses as the seat, in very rare instances, of cystic tumors. The cases reported, however, have been very few. Jager observed one case (Ammon's *Klinische Darstellung*, Vol. II, p. 26, Berlin, 1838), and Mackenzie reproduces ("Treatise on the Eye," p. 97, 1855) two cases reported by Langenbeck in the *Neue Bibliothek für die Chirurgie und Ophthalmologie*, Vol. II, p. 365, Hanover, 1820. In each case the formation of the cyst appeared to follow an injury and there was marked exophthalmos in a downward and outward direction. On account of the rarity of the condition, I have prepared the following abridged translation from the report of the case by Teillais in an article "*De Quelques Tumeurs de la Région Orbitaire*," *Annals d'Oculistique*, Jan. and Feb., 1882.

"T., aged 32 years, fought as a sailor in 1862 in the battle of China. In the combat, an arrow struck him above the internal angle of the left eye. The wound was slight and kept him only a few days in the hospital. He left perfectly cured. In 1877, he began to experience neuralgia, and some months after a small swelling was observed above his left eye. Some time later he was attacked by erysipelas and entered a hospital. The whole of his face was inflamed and he had a fever which lasted a

fortnight. The inflammation disappeared, and he left the hospital. The tumor and the neuralgia still remained.

“ This latter condition became, finally, so intense that he gave up his work. At the internal angle of the eye, a tumor was found the size of the fist. The eyeball was markedly projected downward and outward, the cornea being almost on a level with the tip of the nose. Vision was preserved, but all movements of the eye were impossible. The tumor was soft and fluctuating. The day following his arrival an explorative incision was made, and with a small syringe a bloody liquid was withdrawn. On analysis its composition was found to be a watery fluid containing albumen, fixed salts, hydropisine, urea, epithelium, pigment, etc.

“ An incision was made into the tumor the 16th of July, 1878, and 25 or 30 grms of liquid were drawn out; that time the eyeball rose to its natural position as the fluid entered the aspirator. About 2 grms. of alcohol were injected into the sinus and the result of this seemed favorable, and the following day the pain had entirely disappeared. July 26th, the patient found himself so well that in spite of orders to the contrary, he walked about for several hours. July 27th, he was seized with an intense fever, and a slight redness appeared at the root of the nose. The following day his entire face was invaded with erysipelas, he experienced agonizing pain, and the tumor reappeared. July 29, he became delirious and it was decided to open the sinus by a transverse incision. The cavity appeared enlarged and lined with a perfectly smooth membrane. The wound was dressed with a dry lint compress. Aug. 15th, the patient was discharged. A small fistula remained, but the eye was in its normal position, and only a small cicatrice above the eyebrow was observable.”

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SELECTIONS.

OBSTETRICS.

NARCOTISM IN INFANCY.—The chapter of forensic medicine which deals with the crime of infanticide, exhibits a knowledge of the results obtained by the administration of lethal doses of narcotics to infants, and the post-mortem results induced upon the infant body, when the narcotic having been administered for a longer or shorter time, has proved fatal.

Many instances occur short of criminal intent, where infants are subjected to a longer or shorter course of narcotics, and these illustrate the effects of the drug on the infant during life.

It may be well therefore to advert to some of the clinical evidences which present themselves during the administration of narcotics to the infant.

It will not be necessary here to consider the reasons for the administration of the narcotic, for the cases these remarks are intended to elucidate are such as occur not infrequently in the nurseries of both the wealthy and the poor, wherein it is to be supposed that either the relatives, or friends, or the nurse, with good intention, or in ignorance, believe it necessary that the infant shall be soothed, and that to this end a narcotic is given in small but repeated doses.

Under these circumstances, given a healthy child to start with, certain results will follow with an equally certain regularity :

1. In the early administration of a narcotic, more or less diversified according to the temperament of the infant, a modified degree of excitement will supervene, to be followed by sleep; and this unfavorable condition of things may recur for a period varying from a few days to a week or two. If, however, the repetition of the narcotic be at all frequent, or if it be exhibited in any but a very small amount, this period of favorable narcosis will be proportionately diminished, and the chances of its lethal effect increased.

2. In some infants the effect of the narcotic will be to speedily constipate, for as in the adult so in the infant, a narcotic lessens at once the secretions and movement of the stomach and intestines, and consequently digestion becomes arrested.

There is, however, a class of cases met with in infancy, wherein infants, the subject of imperfect digestion associated with colic, become for a time benefitted by a moderate amount of narcotic. Here the sedative acts by checking peristalsis, and so enables the food to remain a longer time in contact with the digestive juices, and thus to become more perfectly digested. This condition, however, is more frequent in early childhood than in infancy.

A third and more frequent sign of the administration of a narcotic in the infant is the occurrence, sometimes the concurrence, of diarrhea and vomiting. When these occur, a longer time will elapse, than when such conditions are absent, before profound narcosis ensues.

3. In addition to the above, diaphoresis and diuresis may occur, one

or both. Either of these may, and often will be, present in an inverse proportion to the other. The predominance of either will be dependent upon the amount of fluid ingesta, the character of the foods taken, and the condition of the temperature of the weather present at the time. Obviously warm weather or an over-heated atmosphere will promote diaphoresis, while cold weather would augment diuresis.

4. The intestinal evacuations soon alter in character, becoming paler and more solid in consistency, diminished in their frequency, and increasingly more and more in bile; accompanied by a change in color from yellowish-green to verdant green, with or without mucus, and if very constipated accompanied by streaks of blood, owing to the tenesmus which is associated with the expulsion of the hardened, ill-digested feces.

5. Another vital symptom, though of later occurrence than the preceding, is marked depression of the vital powers, evidenced by sinking of the anterior fontanelle. This is accompanied by other signs of want of vitality, viz., feebleness of pulse, loss of weight, an earthy complexion, wasting, especially marked in the pinched and anxious expression of the face. By this time the infant alternates between efforts at peevish whimpering, and imperfect somnolency.

The pupils will be found in the earlier stages of narcotism in infancy to be frequently contracted, but when the stage of fontanelle depression is reached they contract or dilate, and one pupil may be larger than the other. This condition I believe to be dependent upon variations in the amount of fluid present in the ventricles of the brain.

So soon as this stage is reached, any subsequent dose of a narcotic may prove speedily lethal, and the greatest care and caution become necessary to avert an untoward result. It is at this point that I believe the cumulative effect and action of the narcotic assumes a point of much peril to the infant. One of two results may now supervene: either clonic convulsions may set in, though these are not very frequent; or, and much more commonly, profound and perhaps fatal coma.—*H. Cripps Lawrence, M. D., in The Practitioner, May, 1882.*

IPECACUANHA AS AN OXYTIC.—Dr. L. F. Pitkin, of Newark, N. J., reports a case in the *Medical Record* where a hard and resisting os was softened and dilated, and a tedious and painful labor speedily brought to an end by the administration of three 5-grain doses of ipecacuanha at intervals of about twenty minutes.—*Obstet. Gazette.*

MERCURY IN MEMBRANOUS DYSMENORRHEA.—Dr. Ormsby, of New York, gives five cases of painful menstruation, accompanied by the shedding of flakes of membrane, successfully treated with calomel in combination with opium. His formula is as follows:

R Ext. opii, gr. vj.

Hydrarg. chlo. mit., gr. xij.

Divide into twelve pills, one to be given every four hours till the gums are affected. He regards the known efficacy of mercury in all forms of hyperplasia, acute and chronic, as justifying *a priori* its exhibition in a complaint in which the hyperplastic element is recognized by pathologists; and his practice has completely confirmed this view. In each case when the mercurial treatment has been pushed so as to make the gums slightly tender, the next following menstruation has been painless, and the benefit so attained has been permanent without further medication. Painful menstruation is so much a question of habit, that to interrupt it for one month only is almost to break it off altogether. Calomel has been the only salt of mercury tried, as it produces its effect rapidly and with little irritation.—*New York Med. Rec.*

AFTER-PAINS.—A writer in the *British Medical Journal* recommends salicine, in 15 gr. doses every two hours.

SURGERY.

TO PREVENT CHRYSOPHANIC ACID APPLICATIONS FROM SPOILING BED LINEN AND UNDERCLOTHING.—Dr. Fox, of New York, gives the following directions: Make a paste of the acid by rubbing it up with a sufficient quantity of water. In using this paste, smear it over the part previously cleaned of scales by a hot bath of soap and friction. As soon as the paste has dried, which will be in a few minutes, a layer of collodion should be allowed to flow over each patch and harden into a protective coating. In several days, when it falls or is washed off, the application of paste and collodion should be repeated.—*Med. News.*

SIMPLE TREATMENT OF CONGENITAL CLUB-FOOT.—It is unfortunate that so much of mystery and specialism hangs about the treatment of club-foot. It is too generally thought that it consists solely in tenotomies and the application of complicated and expensive shoes of various kinds which none but the specially initiated can understand. And

for this reason cases are often left untreated just when simple treatment would be most quickly successful. For club-foot, like every disease and deformity, is more amenable to treatment in its early uncomplicated stages, and many a case which in later years is cured only after long and wearisome treatment would have been comparatively easily dealt with in its earliest stages. The great objects to be attained in all cases of club-foot are to replace the part in its normal position with the help of tenotomy where necessary, to retain it in that position for a sufficient length of time, and to exercise and stimulate the development of the weakened muscles. This can all be done in congenital club-foot from the earliest days, and ought to be commenced at once. The hand is the proper instrument to correct the deformity, and a plaster-of-Paris splint just strong enough for this purpose is the best means of maintaining the foot in the proper place. This splint if made after the Bavarian pattern, can be removed every day for the foot to be rubbed and electricity applied; or the more common form of plaster-of-Paris splint may be removed for the same purpose every two or four weeks. If practitioners would treat their cases of club-foot in this way from the very first, many would be almost if not quite cured before the child began to walk, when the difficulty of treatment is necessarily increased.—*Lancet*.

ON THE ADVISABILITY OF ENUCLEATING THE AXILLARY GLANDS IN CASES OF REMOVAL OF SCIRRHOUS MAMMÆ.—I. *Is it right or is it wrong to operate for cancer of the breast where the lymphatic glands in the axilla are obviously enlarged from secondary cancerous growth?* The answer to this question depends upon the answers to two others: Can we safely remove cancerous glands from the axilla? and, Does the cancerous infection stop at the lymphatic glands for so long a period that there is time for those glands to become distinctly enlarged before the malignant disease has been carried to, and grown in, internal organs? The practicability of the operation must of necessity vary with individual cases. Where the glands are still freely movable it is easy to enucleate them; where they are firmly fixed down to the chest wall, it is impossible to remove the whole of the diseased structures without serious risk, or even the certainty of fatal injury to the thoracic cavity. Between these two extremities there are several grades of severity. But if we look at the dangers and difficulties of the operation, we shall best arrive at the true answer. By drawing the arm well away from the side, and prolonging the mammary incision outwards, the axilla is easily exposed. The dangers

are the primary ones of wound of the large blood vessels and nerves, and wound of the pleural cavity. As the blood vessels and nerves are very constant in their position the surgeon always knows where his danger lies, and even when the growths are adherent to these parts he can often, by slow and very careful dissection, separate them without wounding either vessels or nerves. The intercosto-humeral nerve, which crosses the axillary space, is most of all exposed to injury, and must be very generally cut or torn across. One common way of avoiding the danger of hemorrhage is to separate the mass to be removed, except at the end next the vessels, and then to throw a strong ligature around this pedicle, and cut the mass away on the distal side of the ligature. This is only a "surgical makeshift." It is far better, by care and patience, especially patience, to separate the growth all round. If vessels of any size are found entering it, ligature them separately. The disadvantages of the makeshift plan are, that the vessels in the pedicle are not so securely tied; nerves as well as vessels may be included in it; and there is no certainty that the surgeon has removed all the diseased tissues.

The secondary dangers of the operation are suppuration in the axilla and thrombosis of axillary vein. In my own experience these accidents have not occurred, and I have found these wounds in the axilla heal very well, if I took three precautions: to put a drain into the cavity, to apply suitable padding to keep the walls of the cavity in apposition, and to keep the arm fixed to the side.

As to the second question, I think all will agree that there is often an interval of many months between the discovery of cancerous infection of the axillary glands and the appearance of signs of cancerous disease in the internal organs. But the *facts* I would adduce in support of this statement are these: (1) That systemic secondary cancer without antecedent glandular infection is very rare, being met with in only about 13 per cent. of such cases. (2) That in cases of death from cancer of the breast, infection of the glands is met with far more frequently than infection of any other organ. Thus, in 128 autopsies, the glands were found cancerous in 115 cases, and the liver, which stands next in order of frequency, was infected only fifty-five times; the lung twenty-eight times; and then comes the great fall to units. What is the meaning of these facts but that the path of the cancerous poison from the breast is through the axillary lymphatic glands, and that the poison is delayed in its passage through these glands, often for a long period? Hence, on pathological grounds, this operation is justifiable. Practically, it is a safe procedure, not adding

greatly to the risk of the simpler operation, and clinically it is successful; for, out of ninety-three cases tabulated by Oldekop and Winiwater, in which this was done, the mean subsequent life was 39.3 months. And Gross states that in as many as one-third of the cases submitted to a complete operation—*i. e.* clearing out the axilla—no recurrence was observed up to so long as six years afterwards.

2. *Is it right, or is it wrong, when operating for cancer of the breast, in which no lymphatic enlargement can be detected, to remove the axillary lymphatic glands?* Practically this is a very simple procedure. A very small extension of the wound allows the finger to be passed into the axillary space, and with it the glands can be readily enucleated, without danger to nerves, vessels or pleura. Or, better, a careful dissection of the axilla can be made. The small twigs of alar thoracic vessels, which are necessarily divided, are not large enough to require any treatment. A small drain should then be put in the axilla and the wound treated as already mentioned. Such a procedure hardly, if at all, adds to the danger of the original operation. But is it to any advantage? I believe it is, for I believe that in the very earliest stage of lymphatic infection it is impossible to detect any enlargement of the glands by the ordinary examination through the skin. Such a case occurred to me quite lately. A patient was brought to me by my friend, Dr. Shaw, of Enfield, with a scirrhus in the right mamma. Neither I nor Dr. Shaw nor Mr. Macnamara, who afterwards saw the case with me, could detect any lymphatic enlargement. But after excising the mamma I, as a matter of routine, proceeded to remove the axillary glands, and then I found that two of them were evidently already cancerous, in one the focus of the disease being about the size of a shot and the other of a pea. My friend, Dr. Heneage Gibbs, has prepared some microscopical sections of those glands, which prove the cancerous nature of the growths. Now here was convincing proof case that had I simply contented myself with excising the mamma, I should almost directly have found a recurrence in the axilla, and this one was sufficient to convince me that cancer may exist in axillary lymphatic glands which cannot be detected by the ordinary methods of examination. The only other explanation is, that had I used proper care and skill I should have detected these minute growths. To which I can only reply, that I examined the axilla repeatedly and with care, and if I made an oversight, so did Dr. Shaw and Mr. Macnamara, and therefore it is an oversight that might be expected to be made. Further, recurrence in the axillary glands, apart from local occurrence, is not uncommon after

removal of the mamma alone. And recurrence in the axilla is far more frequent after removal of the breast alone than when the glands are simultaneously removed. The axillary glands are not of functional importance at the age when cancer occurs.

In conclusion I would formulate my argument thus :

1. Partial excision of a cancer should never be performed.
2. Where breast and axillary glands are cancerous the breast alone should never be excised.
3. That in very many cases of cancerous axillary glands excision can be performed with only slight additional danger, and with great benefit to the patient.
4. That the cases where such excision is not practicable are those in which the growth has spread to the chest walls. Pressure upon, or even adhesion to, the main blood vessels and nerves of the axilla is not an insuperable bar to the operation, if sufficient care be taken.
5. That when no enlargement of axillary glands is to be made out, those glands may yet be infected with cancer, and that, therefore—
6. Even when not evidently diseased, they should be removed at the same time as the diseased mamma, or, in other words, “it is advisable to remove the axillary glands *in all cases of cancer* of the breast submitted to operation.”—*A. Pearce Gould, M. S., in London Lancet, July, 1882.*

SUBCUTANEOUS SECTION OF ADHESIONS FOR REDUCTION OF OLD DISLOCATIONS OF THE SHOULDER-JOINT.—The fibrous adherences which form around the displaced head of the humerus are the great obstacles to be overcome in reducing the luxation. After six months for sub-coracoid luxations, and four months for the intra-coracoid, they are generally so firm as to render reduction impossible. Fracture of the neck of the humerus has already been proposed by Despres for these irreducible luxations. M. Polaillon advocates the subcutaneous division of the fibrous bands, and has been able by this means to reduce a luxation of four months' standing, and recommends that whenever an extending weight of 200 or 300 pounds is unable to displace the head of the bone, the adherences should be divided, antiseptic precautions being taken, after etherizing the subject.—*Revue de Chirurgie.*

MEDICINE.

ACTION OF ALCOHOL ON DIGESTION.—Buchner has made a series of experiments on this subject by adding alcohol to artificial digestive fluids

in a flask, and also by washing out the stomach six hours after a meal, and ascertaining what proportion of the food remained undigested when alcohol had been given or not given along with the food. He finds that alcohol up to 10 per cent. strength has no influence as such upon artificial digestion. When added so as to form 20 per cent. of the digestive fluid it slows artificial digestion. In larger proportions it completely arrests it. Beer, when undiluted, completely stops artificial digestion, and when diluted slows the process. Red and sweet wines have a similar action, while white wines, even when undiluted only, slow digestion. Both beer and wine hinder digestion in the stomach, even in small quantities. When the processes of absorption and secretion are already disturbed wine and beer may completely arrest digestion. They should, therefore, be given with the utmost caution or completely withheld in cases of gastric catarrh.—*Arch. f. Klin. Med.*—*Practitioner*.

THE SYMPTOMATOLOGY OF BRIGHT'S DISEASE.—M. Dieulafoy lately called attention to certain symptoms of Bright's disease (parenchymatous and mixed nephritis), of which too little notice, he thinks, has been taken. The most important of them is frequency of micturition, a symptom which, although frequently associated with polyuria, may exist independently of any increase in the quantity of urine. In some cases the symptom is very troublesome; the bladder has to be emptied twelve or fifteen times a night, and twenty or twenty-five times every twenty-four hours, and this although the total quantity of urine may not amount to a pint. This symptom Dieulafoy proposes to term pollakuria, and it may be manifested in three forms. 1. An early form may attend the commencement of the renal disease, of which it may be indeed the earliest manifestation and of considerable diagnostic significance. 2. A late form which attends the chronic stage of the disease which has commenced acutely. 3. A form in which the symptom is attended with great pain and distress, and is accompanied by tenesmus and spasm of the sphincter ani, lasting from three to eight minutes. Another symptom is irritation of the skin. M. Dieulafoy asserts that it is met with in one-third of the persons suffering from "albuminous nephritis," whether interstitial, parenchymatous, or mixed, and that it is especially frequent in women. This symptom is also met with in different forms. Sometimes it has the character of ordinary pruritus, and may be thus the initial symptom of Bright's disease, preceding for months any other inconvenience. It has been explained by uremia, and has been attributed to an excretion of urea by the

skin, but in one of his cases the symptom was not present, although a large amount of urea was excreted by the skin. In other cases the itching is much slighter, and is described as resembling the sensation produced by the contact of a hair with the skin. The last symptom to which attention was directed is that which is described by patients as the "fingers going dead." It is a sensation of formication or cramp, accompanied by such pallor that the part looks altogether exsanguine. It may last half an hour or so, and then disappear entirely. Rarely both hands are affected, and when it is bilateral and partial the area is always symmetrical on the two sides. It appears to be due to a true vaso-motor disturbance.—*Lancet*.

ON THE TREATMENT OF PHTHISIS BY INHALATION.—Dr. S. Dowse, referring to the recent very valuable discovery of Dr. Koch, thought that the inflammatory theory of tubercle, and Dr. Sanderson's recent lectures at the College of Physicians on Inflammation, tended to support rather than detract from the results of Dr. Koch's original investigations. He said it was more than ten years ago when he first began to treat pulmonary consumption by inhalation; and he regretted that, until recently, he had not carried out his experiments with that care which so important a subject demanded. During the months of September, October, November and December, 1881, he had treated his patients in the North London Hospital for consumption, by several forms of inhalation, and he almost invariably had good results. He thought, however, that the process of inhalation was far from perfect, and he hoped for better results in the future. Short histories and notes of several cases were brought forward as evidence in favor of this mode of treatment. He spoke particularly of the value of acetic ether as an inhalant; in fact, he went so far as to say that this drug was, in his opinion, capable of dissolving nascent tubercle. The mixture which he generally used had the following composition: R Thymol, ziij ; etheris acetici, ziij ; etheris sulph., zi ; creasoti, ziij ; acidi carbolici, m, xv; terebine ad ziv . Ten drops to be used at a time for an inhalation: for instance, two hours in the morning, afternoon and evening, as well as during the whole night.—*Brit. Med. Journal*.

REVIEWS AND BOOK NOTICES.

Prices are always inserted when furnished by the publisher, or when obtainable from the bookseller.

WOOD'S LIBRARY OF STANDARD MEDICAL AUTHORS.

Practical Medical Anatomy. A guide to the physician in the study of the relations of the viscera to each other in health and disease, and in the diagnosis of the medical and surgical conditions of the anatomical structures of the head and trunk. By Ambrose L. Ranney, M. D., Adjunct Professor of Anatomy, late Lecturer on Genito-urinary and Minor Surgery in the Medical Department of the University of New York, etc.

The practitioner who desires to hurriedly refresh himself as to the practical anatomy of some region, is generally greatly annoyed at the amount of cumbersome detail which presents itself in Gray and other standard text books. Under such circumstances, he will find in the book before us just the information he wants, and in the most tangible shape. Dr. Ranney has found a real want, and admirably supplied it.

Materia Medica and Therapeutics. Inorganic Substances. By Chas. D. F. Phillips, M. D., M. R. C. P., late Lecturer on Materia Medica and Therapeutics at the Westminster Hospital Medical College. Edited, and adapted to the U. S. P., by Lawrence Johnson, M. D., Lecturer on Medical Botany, University of New York. In two volumes.

The first part of this work, on organic substances, was issued two years ago. The second part has only just been completed, and is now presented for the first time to American readers, having been adapted to our pharmacopeia. By this adaptation the book is made a very complete one on this subject.

Lectures on Diseases of Children. A hand-book for physicians and students. By Dr. Edward Henock, Director of the Clinic and Polyclinic for Diseases of Children in the Royal Charite, and Professor in the University of Berlin.

The introduction, on the methods to be used in examining infants and children, is especially well written, being filled with useful hints. Part first, on the diseases of the new born, will frequently serve to help the neophyte out of his troubles with old nurses and grand 'ams. The remainder of the book is a plain, straight-forward presentation of the subject.

Mental Pathology and Therapeutics. By W. Griesinger, M. D., Professor of Clinical Medicine and of Mental Science in the University of Berlin, etc., etc. Translated from the German (second edition) by C. Lockhart Robertson, M. D. Cantab., Supt. Sussex Lunatic Asylum, and James Rutherford, M. D. Edin.

The author has added considerably to his first edition, issued in 1845, especially in the parts relating to pathology, etiology, cerebral anatomy, etc. An entire section has been added on the general diagnosis of insanity, and another on idiocy and cretinism.

Diseases of the Ear in Children. By Auton Von Troeltsch, M. D., Professor in the University of Wurzburg. Translated by J. Orne Green, M. D., Aural Surgeon Boston City Hospital, etc., from *Gerhardt's Handbuch der Kinderkrankheiten*. New York: William Wood & Co. 1882. 8vo. Pp. 165.

One's first impression is that this is a large book on a small subject; but this impression changes—indeed, becomes almost reversed—on hearing of the very great frequency with which ear diseases occur in infants and young children: thus, the author found 29 petrous bones of young children out of 47 examined, affected with various degrees of purulent middle-ear inflammation, while Schwartz found the middle-ear filled with pus, in two out of every five new-born children examined.

With such a record of the frequency of these diseases, and in view of the slight attention given to the subject by authors on diseases of children, this book will meet with a cordial reception.

The methods of examination and of treatment are carefully detailed, differing as they do quite materially from those in adults. A chapter on Deaf-mutism completes the book.

The Vest-Pocket Anatomist. By C. Henri Leonard, A. M., M. D. Eleventh Revised Edition. Detroit. 1882. Price, 75 cents.

A convenient book for the student of anatomy. It is founded on Gray's Anatomy, but the author has also made use of Brown's Aids to Anatomy, and Bryant's System of Surgery. Its popularity is shown by the number of editions which have already been exhausted.

The Physician Himself, and What He Should Add to the Strictly Scientific. By D. W. Cathell, M. D., late Professor in the College of Physicians and Surgeons of Baltimore, etc., etc. Baltimore: Cushings & Bailey. 1882. Cloth, pp. 194. Price, \$1.25.

This is a book full of sage and shrewd advice to the young, and hence

inexperienced, practitioner. There are not many things in the book that a wise man will not find out for himself, during fifteen or twenty years of practice, but he who learns them beforehand is that much ahead. The advice is all proper and ethical: there is nothing of the "Pine Ridge Practitioner" about it, nothing to offend the most thoughtful and conscientious. We append a few samples:

Do not over-visit your patients. Excessive attention and numerous visits are rarely appreciated. If you get the reputation of not paying any but necessary visits, it will be a special feature in your favor, and will almost double your practice.

Avoid all such tricks as assuring a timid patient you will not lance his boil, merely wish to examine it, and then suddenly do what you assured him you would not do. Veracity should ever be your golden shield.

Make it a study to remember well all that is said or done at each of your visits, so that all you say and do throughout the case may be consistent, and also take care neither to expose a want of memory or a lack of interest. Were you to ask a patient, "what kind of medicine did I give you last?" he, and his friends, would notice it instantly and think you either felt but little interest in the case or had a dangerous lack of memory.

EDITORIAL DEPARTMENT.

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We have *no authorized Collectors*, except such as carry properly made out bills, *counter-signed by the Publishers*.

HANN & ADAIR, Publishers, Columbus.

TREATMENT OF TYPHOID FEVER.

At the request of a correspondent, we cheerfully give space for the article on typhoid fever, delineating the personal experience of an accomplished and experienced physician and his deductions therefrom.

As to the treatment of this disease, there is, at present, nothing which

II.—3.—6.

can be regarded as settled. Supporting measures, and meeting special indications as they arise, seem to constitute about all. Nothing is heard of the mineral acids; the antiseptic treatment, of Roth and Bell, has scarcely more followers than the "water-diet" system of Luton, while antipyretics, never popular in America, are now little used, even in Germany. That alcohol, quinine, and salicylic acid will reduce temperature, is true. Baths, cold or tepid, will do the same. But no satisfactory statistics have yet been produced showing a diminished mortality under their use, while quinine and salicylic acid certainly produce gastric irritation and thus do harm. Baths are out of the question in private practice. Antipyretics seem to be helpful in some cases, but that is all that can be said in their favor. Indeed, Hankel, Wunderlich's own pupil, who was at one time an ardent advocate of antipyretics, has lately admitted that while they bring down the temperature, *they prolong the disease*. Bristowe says of them, "I must confess that my experience of their use has not impressed me favorably;" while Flint says of this line of treatment, "It neither increases nor diminishes the fatality."

Being admittedly a self-limited disease, the only point would seem to be to sustain the patient until the disease-process comes to an end. This is to be accomplished by no one line of treatment, but by varying the treatment as demanded by each case; controlling the diarrhea, catering to the appetite, securing sleep, stimulating freely and boldly at the proper time, and treating accidents as they arise. That chloral is a dangerous hypnotic, from its effect on the heart, seems to be generally admitted. Heart failure, which comes on so suddenly and with such fatal effect, does not seem to be affected favorably by digitalis; strychnine, recommended highly by Davis, of Chicago, has seemed to produce better results, and to be an agent of good promise.

The giving of quinine, in tonic doses, still has the sanction of common usage, but the number of those who question its utility is constantly increasing.

OVARIOTOMISTS, ATTENTION!—Dr. J. E. Janvrin, of 191 Madison Avenue, New York City, has been selected to prepare the chapter on the History and Statistics of Ovariectomy in the System of Gynecology by American Authors which is to appear at the end of the year. He is desirous that all who wish their cases published should forward to him before 1st October next answers to a printed list of questions which will be sent to any address on application.

THE *Louisville Herald* seconds our nomination of I. Minis Hays (though it misspells the name) for Editor-in-Chief of the American Medical Association. For Assistant it nominates Richard J. Dungleison : a good nomination.

DR. D. A. MORSE, of London, late Superintendent of the Insane Asylum at Dayton, has just opened a private institution for the treatment of nervous and mental diseases, including epilepsy, inebriety, the opium habit, and nervous disorders of childhood. His institution is located at Oxford, Ohio.

THE HAPPY FAMILY.—During the seven years of its existence, no less than *fifteen* members of the corps of instructors of the C. M. C. have retired to private life.

THE AUGUST SUPPLEMENT.

From nearly every County in the State, and State in the Union, have poured in letters of sympathy, cheer, and congratulation over the complete refutation, contained in our Supplement of last month, of all charges brought against ourself or the Board of Health of W. Va.

To seek to divert attention from himself by calling names, is the usual line of defense of the culprit, notwithstanding its almost universal failure. It has failed in the present instance. The school stands self-convicted of graduating a man on a three weeks' lecture course, while the evidence is conclusive that this is no exceptional case, and that other, and grosser, irregularities have been practiced.

The question is frequently asked, Will not this exposure injure the College? Probably not, in the number of its students. The standard of medical requirements is very low in this country, especially in the West; and there are hundreds of young men, whose only desire is to secure a *legal* professional standing, who will seek the place where the necessary document can be obtained cheapest, quickest, surest, and with the least required ability. Such men care nothing for hospitals or clinics, or for museums and other means of instruction; the diploma is their only object, and for such men our supplement will prove a valuable advertisement. Buchanan found professional exposure and criticism no bar to the success of his enterprise, which was only stopped by the stern arm of law. But the success of such enterprises will only hasten the day when all the States will feel the absolute necessity of adopting some means which

- shall, like the Board of Health of West Virginia, serve to protect their people from the Medical Colleges.

Since writing the above and just as the last "form" of the JOURNAL is ready for the press, we have received a copy of a circular issued by the owner of the Columbus Medical College, containing, with other matter, the alleged examination papers of A. M. Dent. It has seemed best, therefore, to hold over some other matter and make room for a few comments on this document, which, however, *does not contain even a denial* of the allegations contained in our Supplement.

1. Of the three articles which appeared in the *Sunday Morning News*, previous to the anonymous communication by Dr. Hamilton, neither Reeves nor Baldwin had the slightest knowledge, except of the last.

2. Dr. H. would like to worm out of responsibility for his scurrilous attack in the *News*, by laying it onto his lawyer; but as he furnished the items of the attack, revised the lawyer's manuscript, sent it to the *News* office as his own, sent it also to the *Wheeling Register*, and even *went to Wheeling to secure its insertion*—he can now scarcely deny its paternity.

3. In the *News* attack, Baldwin is charged with the offense of violating "the rules and practice of the college" by having an oral examination; in the document before us, it appears that at least half of the faculty were guilty of the same offense.

4. To publish what purports to be the examination papers of this three-weeks' graduate is simply a farce. Written examinations conducted in a crowded room, where vest-pocket "aids" are freely used and assistance easily obtained from brighter men, are scarcely above the examinations required by Buchanan, which were conducted by mail. Indeed, so utterly farcical have these so-called examinations proved, that one "Professor" in this school, for several years gave the class a uniform grade of 100—perfect! If the publication of such written examinations is to be a vindication, poor old Buchanan should have a chance. No further comment is necessary on these examination papers, though by what process of marking, a grade of 75 per cent. was given in practice, and of 90 per cent. in obstetrics, is a mystery to the uninitiated.

5. The old *lie* is again re-dressed and brought out to do service, that Reeves said that Dent located the ileo-cecal valve in the rectum, etc. Either Dr. Hamilton has not read Baldwin's letter or Reeves' speech, or he is incapable of understanding the English language. Dent is especially *excused* from having made those blunders. The language of both the

letter and the speech is simply that in the graduating class "one man was graduated who did not know what the iris was, nor the pupil," etc., while the context, in each case, shows that the "one man" was not Dent. If the names of the men who failed to answer, as indicated, are desired, they can be furnished.

6. If the names are desired of other short-time men, in whose interests the "imperative rule" (?) has been waived, they can be furnished.

7. That four members of the faculty have had the manhood to personally express to Baldwin their disapprobation of the high-handed course of the manager of the school, is especially gratifying to him, particularly as they so expressed themselves at the risk of their professorial existence.

8. Finally, in the use of epithets the article is characteristic of its author—truly Falstaffian; and in nothing does this better appear than in the attempt to belittle the Board of W. Va., by calling it a "little machine," "little thing," "little rattling machine." If epithets were only arguments, and mis-statements and insinuations only facts, the author would be invincible in a "public controversy"; but as they are not, the wisdom of his "vow," which he broke on the 6th of August, and again in his present circular, but which he has now renewed, is very apparent.

Dr. Hamilton has simply undertaken to *crush out* a young man who had the manhood to stand up for his own rights as a physician and surgeon, and to oppose schemes that he regarded as dishonorable. His trustees and faculty responded to his undertaking, some tardily—through fear, some gladly—through jealousy, but only to the extent of the original ejection; his subsequent attacks have been made at the instigation of his own bitter malice and jealousy, and without their knowledge or consent.

In conclusion, we quote a sentence from a letter written by a prominent Ohio surgeon to Dr. Baldwin: "He (Hamilton) has ruled so long, and has bullied so many men, that he will not brook resistance such as you have shown. You are a bold, bad rebel, and he, being thoroughly imbued with a Christian thirst for revenge, will pursue you with all the virulence which the exposure of hypocrisy can engender. But I can assure you that among those who know him his malignancy can do you no harm."

We hope we are now done with the College. Nothing but the grossest provocation will lead us to notice it again. Our space belongs to our subscribers and is too valuable.

ANNOUNCEMENT.

A notice was recently sent out by the Treasurer of Columbus Medical College to members of the profession, designed to retard collections from subscribers.

This circular is scrupulously inexact in its statement of facts, and is evidently issued to injure the publishers of the JOURNAL. The facts are simply as follows: Cott & Hann published the *Recorder*, by contract with the college, for what they could make out of it; all accounts, therefore, belonged to them. When that firm dissolved, the accounts were put in as assets, and were *bought and paid for* by the firm of Hann & Adair. No one else has any claim upon them, whatever; and as they are settling up the old business, these accounts should be promptly paid to them. They are responsible business men, and will protect their subscribers.

J. F. BALDWIN.

OBITUARY.

At a meeting of the Regular Physicians of Lake County, the following resolutions were adopted:

WHEREAS, It has pleased God to remove by death our professional brother, Dr. S. C. Brown, therefore,

Resolved, That with sorrow we render this last tribute of respect to our departed brother who has distinguished himself in his profession by a life-long and zealous devotion to the interests of suffering humanity and whose devotion to his brother physicians in times of distress and sickness entitles him to the respect of all.

Resolved, That while we contemplate and honor his intellectual ability, his eminently useful life, his irreproachable character and those sterling qualities that gave him the respect of a large circle of friends, we deeply deplore and share the sorrow of his afflicted relations and friends and tender them our warmest sympathies.

Resolved, That a copy of these resolutions be printed in the COLUMBUS MEDICAL JOURNAL, our county papers, and transmitted to his friends.

DR. E. B. ROOT,	} Committee.
DR. F. H. PRICE,	
DR. W. H. SHERWOOD,	
DR. C. F. HOUSE,	

NOTES AND COMMENTS.

REGARDING A COLD IN THE HEAD.—The French have a saying, “All that physicians have been able to do as yet for a cold in the head is—to call it *coryza*.” The following conversation summarizes also some very prevalent modes of treatment :

“What do you do for a cold in the head?”

“I treat it—with contempt. And you?”

“I? When I have a cold in the head—I sneeze.”

POST MORTEM SIGNS OF DROWNING.—From an analysis of one hundred and seventy cases of drowning, of which the appearances are arranged in tabular form, Dr. F. Ogston, Jr., draws the following conclusions :

1. When an external examination of the body only is allowed, if abundance of water pours from the mouth on turning the corpse face downwards, and if white watery froth is found at the mouth and nostrils, or if it may be made to issue from them on compressing the chest, we may be justified in giving an opinion as to the probability of drowning, especially when the accessory signs, viz., rosy redness of the face and front of the chest, gooseskin, and bleaching and corrugation of the hands, are well marked, presuming always that no lethal injuries are seen on the body which would appear to have been inflicted before death, and no traces of corrosive action, etc., from poisons be observable about the lips, hands, clothes, etc., but that to justify us in giving a more positive opinion we ought to have furnished to us a detailed account of the locality in which, and the circumstances under which, the body was observed before its removal to the place where it lies for examination.

2. That where a complete inspection of the body is permitted, we may give a more positive opinion when, in addition to the external appearances, water in marked quantity, mixed with white watery froth, is found in the lungs and stomach, and also, perhaps, when a large quantity of watery fluid is seen in the pleural cavities, when sand, seaweed, etc., are found in the bronchi, or even in the trachea, when the lungs are bulky or protrude on the removal of the sternum, and when the blood within the heart is wholly fluid—especially when with these signs we find marked appearances of asphyxia in the heart, lungs, liver, etc.—*Edinburgh Med. Journ.—Phil. News.*

SEVERE.—A hospital nurse, being asked which was the most dangerous case in the ward, pointed to the surgeon's case of instruments and said, "That one!"

"A MODEL (?) INSTITUTION." The *Maryland Medical Journal*, under the above caption, devotes a column editorial to the Columbus Medical College, which concludes as follows:

"We have now in this city four medical colleges, with the prospect of a fifth in the not distant future. There will necessarily be a keen rivalry between some of these, and the desire for large classes and success will prove a strong temptation to relax in the requirements relating to attendance, fees and examinations. Let us be doubly careful that no just ground for censure attach to us. Better that the colleges perish than that the honor and usefulness of the profession should be sacrificed.

"May heaven defend us from ever witnessing in this community such things, or any approach to them, as have been brought to light in Columbus. May no rivalry, no supposed necessity, no engrossing self-interest, induce the authorities of *our* colleges to make any such sacrifices of decency, principle and morality."

AGAINST MOSQUITOES.—A correspondent of the *Druggists' Circular*, from Sheepshead Bay, a place celebrated for the size of its mosquitoes and the number of its amateur fishermen, recommends the following as a very good mixture for anointing the hands and face while fishing:

Oil of tar.....	}	aa 3 j;
Olive oil.....		
Oil of pennyroyal.....	}	aa 3 ss;
Spirit of camphor.....		
Glycerin.....		
Carbolic Acid.....		3 ij;
Mix. Shake well before using.		

PROF. R. C. KEDZIE, of the Michigan State Board of Health, is authority for the statement that the addition of borax to the starch with which fabrics are dressed, will render them unflammable. One teaspoonful of borax to a pint of starch is the proper proportion. It is claimed that the gauziest and most inflammable textures, when treated in this simple way, are rendered absolutely flame-proof.

"DENT-ition is sometimes fatal."

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COMMUNICATIONS.

ANESTHETICS.

BY G. P. IKIRT, M. D., EAST LIVERPOOL, O.

What is the safest anesthetic agent? How much greater is the risk from chloroform than ether? How many times we have heard the questions asked, we cannot now recall; but so often that we might, with profit, consider briefly a subject of so much importance to both patient and surgeon.

For centuries, toilers in the science and art of medicine sought for some agent, by the use of which insensibility to the pain of surgical operation could be procured; but the nearest the ancients could approach to it seems to be profound narcotism from the use of powerful anodyne mixtures and lotions. So very difficult did it seem to find an agent capable of producing the desired effect, that many deemed it beyond possibility. Not many years since, the great surgeon Velpeau, of Paris, told his pupils that although enthusiasts at different times had vainly imagined that some means might be adopted to allay the pain of surgical operation, yet such an idea was entirely chimerical and must ever remain so. The thing, he said, was impossible, and all hopes of it but a vain delusion. And yet, in five years from the time Velpeau uttered these words, he himself amputated limbs and performed other grave operations, whilst his patient lay, unconscious to pain, quietly sleeping from anesthesia.

Well may we extol its virtues and hail it as a boon of inestimable value; but let us not forget that the administration of any anesthetic is

fraught with a greater or less degree of danger. The anesthetic acts by the passage of its vapors through the walls of the pulmonary air-cells, into the blood, and its influence is exerted through the blood on the nerve centres. The initial effect is disturbance of function, while the subsequent effect (when the central nervous organs are invaded,) is paralysis of function. The initial effect most generally assumes the form of exaltation, the general appearance of the patient resembling in a marked degree that of the early stage of alcoholic intoxication. The subsequent effect, or second stage, is the stage of depression, caused by the paralyzing effect when the central organs are overcome. This stage is reached by successive changes from the state of exaltation, *i. e.*, excitement gives way to calmness, sensibility grows less, pulse recedes, respiration becomes more deep and more full, voluntary motions cease, consciousness fades, and when reflex movements are abolished the patient is utterly insensible. This condition may be maintained, and respiration and circulation be continued as in a person in profound sleep. But if this line be crossed by the pushing of the anesthetic, syncope may occur at any time, respiration and circulation suddenly cease, and death close the scene.

The anesthetic agents that have been the most frequently employed are chloroform and ether. The former, introduced by Sir James Y. Simpson, of Edinburgh, about the year 1847, has been frequently employed by European surgeons, and on account of its convenience of transportation, it has always received the preference in military practice. While it is probable that the first operation performed under ether was by Dr. Long in 1842, it was not brought into frequent use until the year 1846. Ether has been given the preference by American surgeons, although chloroform has been until quite recently also largely employed. Each agent numbers among its warm advocates men of eminence and ability, and amid conflicting opinions and contradictory observations, it is not always easy to decide which in a given case is preferable.

If chloroform is employed, purity is a matter of vast importance. Prof. Regnault, some time since, published some tests which he says the surgeon may himself employ. First—the sweet odor of the chloroform. Second—it should not redden litmus paper. Third—it should give no precipitate nor even produce turbidity when shaken with a solution of nitrate of silver. Fourth—it should not become colored when carried to a boiling point with concentrated solution of caustic potash. Fifth—sulphuric acid should not be blackened when brought in contact with

chloroform (an old and well known test). There are other tests, but they can only be practiced by the chemist. Prof. Regnauld states that no chloroform can be regarded as pure which does not satisfy the above conditions. However pure it may be, it is constantly in danger of undergoing spontaneous changes, so that its purity requires verification from time to time.

The advocates of chloroform claim preference for it because it acts more promptly, has a more agreeable odor, does not cause as much excitement, is more convenient of transportation, always acts safely upon children, and produces less gastric disturbance than ether. This latter may be questioned, as either of these agents is apt to provoke vomiting if administered after a meal, while if the stomach be comparatively empty vomiting may not occur from either. Especially is this true if the operation be trifling, and anesthesia be not long continued. That chloroform is not so irritating to the lungs as ether has been established. It is likewise true that young children bear chloroform better than adults, but it is quite probable that some have succumbed under its effects, as there seems to be no physiological reason, beyond increased rate of respiration and circulation, for special immunity for those of tender years.

Ether, on the other hand, can be administered in all cases where chloroform is admissible; and it possesses advantages over chloroform, very great, by being a cardiac stimulant, while chloroform is apt to produce cardiac sedation. It may therefore be given in cardiac weakness, either from dilatation of the ventricles or fatty degeneration, with much less risk than chloroform. Also, in the aged or weak subject, or after severe shock, where chloroform would be hazardous in extreme. Ether acts more slowly and its odor is not as agreeable as that of chloroform, but the great matter in the choice is that of safety, and that agent should be employed which places the life of the patient in the least possible danger.

It is claimed that chloroform may be given to women in labor with impunity. This is incorrect beyond a doubt, and therefore dangerous teaching. Death from its use at such a time has occurred. In a table of one hundred and sixty deaths from chloroform given by Turnbull, three are reported to have occurred during parturition. (Manual of Anesthesia, second edition.)

It is impossible to more than approximate the ratio of mortality from anesthetics, since the number of administrations is unknown, and many of the deaths reported are included in different tables, while doubtless many deaths have occurred that never have been reported. It is consid-

ered, however, that chloroform has caused the great majority of deaths, but this fact alone is not sufficient to condemn it, as it has also been employed more frequently than other agents that its mortality would as a consequence be expected to be greater. Turnbull, in 1879, recorded 370 deaths from chloroform. In 1870 Dr. Andrews, of Chicago, had collected 117,078 cases of chloroform inhalation with 43 deaths; a ratio of 1 to every 2,723 inhalations, while he places the ratio of deaths from ether at 1 to every 23,204. Dr. Coles, of Virginia, reports 52 deaths from chloroform in 152,260 inhalations, or one to every 2,773; and 4 deaths from ether in 92,815 inhalations, or 1 to every 23,204.

It is remarkable how nearly the observations of these two gentlemen agree, and also that they vary but little from their English brother, Dr. Richardson, whose report up to 1870, showed 11 deaths from chloroform in 35,163 inhalations, or 1 to every 3,196. Perhaps the most reliable estimate, as it is more recent, that is given in the International Encyclopedia of Surgery.

M. Paul Bert, of France, has recently communicated to the Paris Academy of Science some important facts relative to the use of anesthetics. After experimenting upon the lower animals, he says: In a graduated series of such mixtures of increasing strength, one is found just sufficient to cause insensibility, and proceeding higher a dose is reached which kills. The interval between the two points, the anesthetic dose and the fatal dose, M. Bert calls the working zone. He has sought to determine it for various agents, ether, chloroform, amyline, etc., and has reached the conclusion that in case of all these agents, the fatal dose is precisely double the anesthetic dose. When an animal was made to breathe in the way indicated (placed in a chamber containing air along with some proportion of some anesthetic) a mixture about the middle of the working zone, it was very quickly anesthetised and remained perfectly quiet in some cases two hours, not requiring any attention or concern. But he points out a fact the most important when he says: The working zone is often very narrow. In the case of chloroform, while 8 grams in 100 liters does not suffice to render a dog insensible, 20 grams kills it (an interval of less than 12 grams). Ether is much less dangerous, for between the active and the fatal dose, there is an interval of 40 grams.

These experiments show that the risk from chloroform as compared with ether is decidedly in favor of the latter, the danger from chloroform being more than $3\frac{1}{4}$ times that of ether. An anesthetic acts, not by the quantity inspired, but according to its proportion in the inspired air;

hence, he adds, the statements of surgeons as to how much they put on the compress, have little value. He farther shows that the working zone for protoxide of nitrogen is more extensive than for the other substances specified, the ratio between the limiting doses being as one to three.

Chloroform and ether combined have been extensively employed. According to the statistics of Dr. Coles, two deaths occurred in 11,176 inhalations, or one to every 5,588. The death rate seems to be decreased as the quantity of chloroform in the mixture is decreased. The mixture now very largely employed in Europe, known as the Vienna mixture, consists of three parts of ether and one of chloroform. "Under the use of this preparation 8,000 operations have been performed without a single accident." (*Wein Med. Zeit.*)

Bichloride of methylene is another substance employed to a considerable extent, especially by English surgeons. It resembles chloroform in appearance and odor; its effects are also very similar in many respects.

Spencer Wells has extensively employed this agent, considering it less dangerous than chloroform. In this he is doubtless correct, taking as a basis the reports of Dr. Coles, which show only two deaths from this agent in ten thousand inhalations, or a ratio of one to five thousand, while his ratio for chloroform is one to two thousand eight hundred and seventy-three. More recent observations prove it equally, if not more, dangerous than chloroform.

Amyleine, a transparent, colorless fluid, with a disagreeable odor, has also been employed. It exists as a constituent of petroleum, or may be distilled from a mixture of amylic alcohol and zinc chloride. It is usually considered more dangerous than chloroform. Dr. Snow administered it to over one hundred patients, but the occurrence of two deaths among that number caused it to be rejected. Nitrate of amyl, has also been used. It is a colorless fluid, prepared by heating together nitric acid and pure amylic alcohol. Its effect is too powerful for safety. A professional friend informed me that to his knowledge, two deaths from its effects had occurred in one of our Western hospitals. Nitrous oxide, or laughing gas, was at one time highly extolled by some American surgeons, but as the insensibility caused by its use cannot be safely prolonged more than a few minutes, because the blood does not receive enough oxygen to sustain life, its use should be restricted to brief operations only. It is much employed by dentists.

Chloroform, ether and alcohol, in various proportions combined, is doubtless the anesthetic of to-day, or least is growing rapidly in favor,

from the fact that the paralyzing effect of the chloroform upon the heart is partially antagonized by the stimulating effect of alcohol.

Chloroform may produce instant death by paralyzing the heart, and this cannot be foreseen. A dose of digitalis given half an hour before the administration of chloroform may counteract its influence over the heart, and if necessary may be repeated hypodermically during the operation, especially if long continued. The proportion of each agent in the mixture is, chloroform 2 parts, ether and alcohol each 3 parts. Billroth's favorite mixture is composed of 3 parts ether, and chloroform and alcohol each 1 part. It will be observed that both contain near the same amount of ether, and that while the first preparation contains a fraction more chloroform, it also contains nearly twice the amount of alcohol.

My own combination (used four years,) consists of ether and alcohol each 2 parts and alcohol 1 part. This combination I have found to act more readily than ether, and to be accompanied with dangerous symptoms less frequently than chloroform; although in several instances its administration was attended with symptoms requiring prompt measures, and on their account I have come to realize the benefit of an alcoholic stimulant administered a short time previous to the anesthetic, or, in the absence of an alcoholic stimulant, a dose of carbonate of ammonia.

Accidents from anesthetics call for promptness on the part of the surgeon and his assistant. The danger signals (aside from paralysis of the heart, when no warning is given,) may be briefly noted as, violent resistance on the part of the patient, with turgid countenance, stertorous breathing, deep moaning, pulse irregular, or almost gone, blanched countenance, respiration growing slower, lips becoming of a deeply purple hue, features assuming a cadaveric appearance. Any of these signs should be heeded, as they demand either more air in combination with the agent inhaled, or its complete withdrawal. In case of an accident the surgeon must know just what to do, and know how to do it quickly, that valuable time be not consumed. He should, therefore, always be prepared to meet these emergencies before commencing to administer any anesthetic; for there have been numerous cases (aside from death by paralysis of the heart,) where every precaution and the most prompt measures have proved alike unavailing. Restorative measures should be employed with some degree of system. The greatest dangers that threaten are the cessation of respiration and of the action of the heart. Should the former threaten, the administration must be stopped, the lower jaw pulled down, mouth cleansed from mucus, tongue

pulled forward, head thrown well back, free access of pure air allowed by opening doors and windows, sudden slaps on various parts of surface, cold water dashed suddenly and forcibly upon face and upper part of chest, irritation of mucous membrane of nose by means of a roll of paper saturated with ammonia, artificial respiration, etc., etc. If the heart beats feebly, or has stopped, a large cloth wrung out of hot water should be applied over it, and this replaced by another every few seconds, while at the same time the patient should be inverted, and so retained if necessary for two or three minutes. If still no signs are favorable, hot water should be poured from a jug or pitcher at a height upon the chest, over the heart, and at the same time use the battery, if at hand, the poles applied on the diaphragm and over the spine; or one pole over the track of the right phrenic nerve in the neck, and the other over the right sixth intercostal space. Artificial respiration should also accompany the use of the battery, with warmth and friction to limbs. Persevere; success has sometimes crowned efforts well directed, when scarce a ray of hope remained.

A mixture of chloroform, ether and alcohol is, without a doubt, beyond all comparison, the safest anesthetic agent that has, to any extent, been employed. There is, so far as known at present, no absolutely safe anesthetic. This must be apparent to all from the fact, that a patient in a condition of profound anesthetic unconsciousness is, of necessity, in more or less danger; and this important fact should never be lost sight of.

It is quite probable that the impunity that has attended the frequent use of these agents, tends often to beget too great a confidence in their safety, and hence a certain degree of carelessness, which, to say the very least, imperils, unwisely and unnecessarily, the life of the patient. Especially is this the case when the anesthetic is given into the hands of those unskilled, as shown by the crowding of the agent in the start; a habit most dangerous and pernicious, and which cannot be too strongly condemned, and hence who are not even able to see and realize when life is placed in great jeopardy, by the occurrence of some symptom which imperatively demands the withdrawal of the anesthetic. The assistant that administers the anesthetic should be competent; for he assumes a duty equally as important, and in many instances more risky, than that of the surgeon who is to operate. Neither should be responsible for the neglect of the other. Each has a duty devolving upon him, and each should discharge his duty alone, giving it his undivided thought and attention.

INFLAMMATION OF THE STOMACH AND DUODENUM.

BY S. C. DUMM, M. D., CONSTANTIA, O.

Having had a number of cases of gastritis, or gastro-duodenitis, ranging from the acute to the sub-acute and chronic variety, during the past four years, I desire to lay before the profession their causes, conditions and treatment. In the first place, I am fully persuaded that acute gastritis is more common than is taught by authors. Dr. Flint says "it is one of the rarest of diseases." That may be the case in the eastern cities, but it is not so in the west, especially where malaria is rife. Within the bounds of my practice there has been an unusual number of cases during the past four years. The acute cases prevail in August and September, generally; the sub-acute and chronic, during the spring, autumn and winter. My first case of the sub-acute form took place in the spring of 1877. The first cases of the acute form were in the hotter months of the same year. There were but two cases of the acute form the first year. During August and September of 1878 there were twenty-five intensely acute cases, with also a great many of the sub-acute form. In 1879 there were a few cases of the acute and chronic, or sub-acute, as also there has been each succeeding summer since.

Some of the acute cases set in with dysenteric discharges, which are easily controlled. But sudden checking of such an acute disease is almost invariably followed by a seeming metastasis to the stomach. Both the acute and sub-acute have been often complicated with intermittent and remittent fevers. In the beginning of such complication the malarial trouble would seem to be in the ascendancy; but just so soon as a course of quinine was given the malarial symptoms abated, with a full development of the inflammatory difficulty. Sometimes when it was thought a simple bitter tonic was only necessary, the stimulating effect of the alcohol in that preparation would be the match that would light the fire. The puerperal state, and in fact every condition that depressed the general system, favored its development. Those who had it one summer were apt to have it the next. One patient had the acute form three summers in succession. Some, after having the acute form, have the sub-acute the summer following.

The acute form generally runs from five to eight weeks; the sub-acute, from one to three; the chronic, where ulceration followed the former varieties, from eight to twelve. The acute form affected persons of adult life, generally from middle life up to old age. Children and young

adults were affected generally, or always, with the sub-acute form. Few children were affected.

Probably one-third of the cases were taken down gradually. There was general malaise, loss of appetite, costiveness, pains and aches in the muscles and bones, scanty, high colored urine, uneasiness in the stomach, or fullness and pain, and more or less soreness over the stomach and duodenum, intense thirst, and a feeling of weight in the stomach. The tongue was heavily coated, and dry. The remainder of the cases were taken with a severe chill, followed by fever lasting from twenty-four to thirty-six hours. If accompanied with malarial symptoms, the fever returned at regular intervals. There was in these unquenchable thirst, with more or less burning pain in the esophagus and stomach, with nausea and vomiting. There was a dry, parched tongue, pulse from 80 to 120 at first, with more or less delirium while the fever lasted, and great restlessness.

As above stated, there was tenderness in the epigastric region. With acute cases there was also a sharp pain under the lower part of the sternum. In these cases more or less blood was spit up every day, and in all an enormous quantity of mucus was spit up. In the worst cases there seemed to be a raw-sore feeling from the pharynx to the stomach. The pulse, after the first two or three days (unless there was malarial complication) came down to below health, and was very weak and often irregular. The nervous system being blunted, respiration was also irregular. In one case the patient would fall into a deep stupor, when he would cease breathing for some moments, until engorgement of the lungs would take place, when he would give four or five full respirations and then fall into the same stupor. This attack was brought on by drinking enormous quantities of water. The patient crawled to the well in the night, while the attendants were asleep, and drank, he said, nearly a bucket of water. It was with difficulty he could be revived. The urine was scanty and high colored from the beginning, and during the worst stages, in a few cases, it would almost be suppressed for two or three days. The tongue peeled off in all the acute cases after the first few days, leaving it sore with a red glazed appearance. In the worst cases the tongue was so swelled, stiff and sore, that when an effort was made to protrude it, it would crack and bleed. The intense dryness continued for the first two or three weeks of the disease, when it would begin to moisten on the sides and the red, glazed appearance would subside, and by the fifth or sixth week it would become more natural. The soreness in

the stomach gradually subsided by the fourth or fifth week, but the patient could not take solid food until two or three weeks after getting up. The bowels were always torpid unless there was dysentery in the start. The mouth and lips were generally inflamed and ulcerated.

The treatment was, first, a thorough cathartic, generally of calomel. This seemed to be the only remedy that would settle the stomach and allay the irritation. If there were malarial symptoms, quinine in the shape of sugar-coated 2-gr. pills, was given, for, in all cases, where the powder or solution in sulphuric acid was given it would increase the fever and dryness of the tongue, and produce more difficulty in the stomach. It would not control the paroxysm, but would put the patient back for two or three days. After the paroxysm was controlled no quinine was given for the above reason.

For the stomach, after arresting the fever, small doses of morphia and bismuth were given; also, gum water and lime water, if there was much acidity present. Pieces of ice were kept in the mouth to allay thirst, but no water of any kind taken into the stomach for four or five weeks. This may look unnecessary and cruel, yet it was the only way to save them. Patients who persisted in taking it were glad to dispense with it after the first drink on account of the distress it produced. Just here I want to enter my protest against swallowing pieces of ice, or drinking cold water in cases of acute or sub-acute gastritis. I never gave it to a patient that it did any good, but a great deal of harm. I never drink it but what it produces thirst and irritation of the stomach. The reaction following its reception in the stomach is certainly similar to that produced by applying it to the cheek, a state of capillary congestion. This condition often produced will finally produce the condition you are trying to combat. Hot water is far preferable, and may be given in these cases.

Neither tea nor coffee could be drank during this disease, but all could take skimmed milk in small quantities, as one to two tablespoonfuls every hour. Generally one tablespoonful every hour was sufficient to allay thirst and nourish the patient. Sometimes it was necessary to make this one-fourth lime water. After the first three or four weeks of the disease had passed a soft boiled egg could be given once a day. The sub-acute diseases were taken gradually, but were never confined to bed more than one or two weeks. They had distress in the stomach, but not of an acute form. There was inability to digest anything but liquid food, and the digestive organs were left in a weakened condition for weeks following.

It was impossible to hurry these cases. Stimulants increased the gastric irritation; not a drop of wine, brandy, whisky or beer could be given without distress and injury. Nothing but a soothing treatment and skimmed milk diet could be employed, and he who would do more would only hurry the patient to the grave. *No irritating medicine, as quinine or spirits in any form of gastric, or gastro-duodenal, inflammation or catarrh, is indicated, unless in malarial complication, when only enough should be given to arrest the paroxysm*; I put this in italics, for I want to impress this truth upon the profession. There is just as much reason in pouring whisky in an inflamed eye as into an inflamed stomach. The mucous membrane of the stomach and duodenum is swelled and thickened, and the glands, whose secretions are so essential to digestion, are closed up.

With this treatment all my patients recovered, except two or three aged persons. If a patient has a sore stomach, with jaundice, counter-irritation, with morphia internally, is better than bitters and calomel, or podophyllum. We are to get rid of the inflammation that closes the gastric glands and the bile and pancreatic ducts, then calomel is the sheet-anchor.

In cases where the stomach would not retain any food, nourishment was given by the rectum. Injections of milk, beef tea and brandy were given in this way successfully. In two cases life was sustained in this way for ten days, or longer. Where there is insomnia, bromide of sodium may be given. In all the cases before mentioned, there were but few that had jaundice; the skin in a few showed some indications, yet no case of real icterus occurred. But there are cases in which that almost always occurs as a complication, which I will now describe. Children and old persons have not the ability to digest animal food that persons of middle life have. The worst cases of gastro-enteritis occur in children under five years, produced by eating chicken or fresh beef, and not in great quantities either. Christmas and Thanksgiving dinners are prolific of catarrh of the stomach and duodenum. Persons after eating turkey with pie and cake, commence complaining of the stomach; this is followed by more or less soreness, and in a day or two the urine becomes a thick dirty brown color, and very scanty. There is general debility, nausea, loss of appetite, sometimes vomiting. After a day or two the conjunctiva becomes a deep yellow, then the whole body becomes of an icterode hue. There is headache, pains in the limbs and back, costiveness; if the catarrh is confined to the stomach and duodenum, or if it extends to the small intestines there is invariably diarrhoea for the first

few days. The gall bladder becomes distended, and the bile ducts occluded, producing more or less swelling of the liver. There is great tenderness over the stomach and liver. The pancreatic duct also becomes occluded. As the swollen condition of the mucous coat of the stomach and duodenum produces occlusion of all the important glands that are concerned in furnishing the digestive fluids, a milk diet is the only one to be employed, the milk, as recommended before, being given in small quantities and often, combined with lime water, if necessary. Counter-irritation should be made over the stomach, and, unlike the first cases I have described, these are benefitted very much by judicious treatment. Morphia, internally, with bismuth, must be given until the soreness subsides. In the acute stage the bowels may be moved by an enema, or with castor oil. After the soreness subsides two or three doses of calomel of five grains each, given every three hours, followed with castor oil, if necessary, will unload the bile ducts, and start the bile into its right channel, thus relieving the kidneys of their excess of work in eliminating the bile. The appetite will now return, and an addition may be made to the food. A soft cooked egg will generally set well, and chicken broth may be added, but no bread, rice or meats of any kind should be allowed for several days. The stomach may be toned up with a pill composed of rhubarb, 2 grs., and nux vomica ext., $\frac{1}{3}$ to $\frac{1}{2}$ gr. No tincture will be tolerated. Cases where the liver is much congested and swollen will be from one to two months in recovering, and large doses of calomel should not be given until the enlarged condition has subsided. With care in diet and treatment no case of catarrhal jaundice need prove fatal, unless in a very aged person. No stimulants, except by rectum, should be given. No quinine by the stomach, unless there is malarial complication, then it should be given in sugar-coated pills. In some of my cases, where the family opposed the use of calomel, I tried podophillum, rhubarb and dandelion faithfully, but without any effect. One case in particular, a young lady about 25 years of age, who was taken after indulging in a good Christmas dinner, I treated with the so-called vegetable cholagogues until the first of February without any perceptible effect. She was terribly jaundiced, and even after the soreness was gone, the jaundice remained. I finally persuaded her to let me administer one dose of calomel, promising her that if it did no good I would not ask her to take any more. I gave her about 20 grs., and it had a wonderful effect. She began to improve at once, and two or three more doses completed the cure.

In all these cases there is left a tendency to relapse for three or four months.

There is another class of cases that we are often called to see, that we call neuralgia of the stomach. The patients are not confined to the anemic, on the contrary, they are apt to be among our healthiest looking and heartiest eaters. I can recall two other cases, where the patient has been troubled for a period of five or six years, having to send for a physician every few weeks to ease the pain. Physicians are apt, in such cases, to administer a hypodermic of morphia, which will give ease in a few minutes, and then leave, thinking they have done all that is necessary; but upon the next little error in diet, they are called upon, to go through the same process. When a doctor has got his patient eased, his work has only just begun; for, if he will examine carefully, he will find there is chronic catarrh of the stomach, and congestion of the liver, which will require from one to three months to remove. There is but one way; rest in bed if necessary, counter-irritation with blisters, an occasional laxative of oil, or an enema, daily, morphia internally, or paregoric chalk mixture, as often as necessary to keep down all pain, and especially at fifteen or twenty minutes before meals. These cases all have distress after eating; this is caused by the contraction of the muscular walls of the stomach upon the food, irritating the sensitive mucous coat. What we want is, to give our opiate long enough before eating to influence the nerves of the mucous membrane; then the patient will digest without discomfort. This treatment must be persisted in, with a milk diet, until all the soreness is gone. Then *nux vomica* and *rhubarb* can be given, or, if there is jaundice, a dose or two of *calomel*. The patient can, in two or three months, sit down and enjoy a good dinner of roast beef or turkey, with pie and cake, and feel well. One patient of mine, a sufferer for eight years, has not been troubled now for four years, and is well and hearty. I kept her on this line of diet and treatment for about two months, and kept her in bed four weeks.

There is no way to do, in these chronic cases, but to be inflexible in the mode of diet, and persistent in treatment. The patient will ask if he can't eat just a bite of some little thing, a piece of cake or pie, or jelly, or what-not; the answer must be invariably, no; for often in indulging them in a bite or two of something, we have everything undone. The patient becomes discouraged and we are defeated. We must impress them with the necessity of seconding our efforts by strict attention to diet.

A CASE OF SPINA BIFIDA.

BY C. L. MORGAN, M. D., ALLIANCE, OHIO.

Mrs. K. — was delivered on the 13th of April of an eight pound girl, perfect in every particular, with the exception of a spina bifida, situated over the lumbar vertebræ. The sack was circular in shape, having a diameter of about five inches, and, when distended, an elevation of about two inches. A portion of the arches of the vertebra were wanting, the sack communicating directly with the spinal canal.

On the second day we found the sack much more distended than before, and on consultation decided to remove a portion of the fluid. This was done by making a small incision at the lower edge of the sack. About two ounces of the fluid escaped, when the child went into spasms of a tonic nature. These were but slight, however, and after they ceased the child seemed to rest much more easily than before. It took considerable nourishment, and made the usual efforts to nurse. It continued to do pretty well for a week, when it began to fail rapidly and finally refused food altogether. The sack became inflamed, and the cuticle soon showed signs of ulceration, and finally broke down entirely. At this period the pain was evidently quite severe, as the child would cry out sharply, and draw up its face into a distorted shape. The legs, which at first were in a normal condition, began about the second day to draw up and assume the appearance of club-foot. This increased each day, and at the death of the child the legs were flexed upon the thighs and the thighs upon the abdomen so strongly that they could not be straightened without great effort. On the ninth day it refused food altogether, and kept up a continuous cry, of a painful and distressing nature, till its death, which occurred on the tenth day. During the last hours of its life it was reported to have been in a succession of spasms, which continued till life was extinct.

A peculiarity of the case was the condition of the mother during gestation, which, in my estimation, had much influence in causing the malformation of the child. From the earliest moments of this period, the mother showed great susceptibility to nervous impressions. If she saw certain things which were contrary to her idea, she would vomit. For instance, she saw one day last winter, a woman on the streets with a light calico dress on. Before conception, she would probably not have noticed it, but at this time it brought on immediate emesis. At another time, she saw the policemen taking a woman to the city jail, and before

she had time to really take in the situation, she was compelled to evacuate the contents of her stomach. If she allowed her mind to dwell upon anything distasteful, it would act as an immediate emetic, and give her much uneasiness. She never had any especial nervous shock, but was continually being impressed with little things, that never amounted to anything before. She would vomit almost every day—mostly in the morning—frequently at night, and had but little appetite during her entire pregnancy.

The question has often occurred whether this nervous irritability had any influence in causing the spina bifida, or whether malformation was brought about without any influence from the peculiarities of the mother. With my limited experience with the condition I am unable to answer, but would state that in my opinion, spina bifida is a malformation caused by certain nervous influences, during gestation, acting through the mother upon the child.

MUSCULAR AUSCULTATION IN THE DIAGNOSIS OF DEATH.

BY P. M. WHITE, M. D., AURELIA, IOWA.

Every one is aware that by placing the tip of a finger in the auditory meatus a roaring, rumbling sound is heard, said to be due to the tremor or fibrillation of muscular fibres. This same sound is heard over all structures containing a large amount of muscular fibre, whether the muscles be in action or repose. It is heard more distinctly over a large flexor or extensor. In the dead body, when the muscles have parted with their nervous supply, and the myogen coagulates, of course this fibrillation is no longer present and sound is abolished. If this be true, then why is not muscular auscultation of some diagnostic value in the so-called state of "suspended animation?"

SELECTIONS.

SURGERY.

CHRONIC CYSTITIS.—Dr. W. E. Shaw, of Cincinnati, reports in the *Clinic*, of July 29th, a case of cystitis, of ten years' duration, following a stricture, which was permanently cured by the injection of an ounce of a gr. xx solution of nitrate of silver. The bladder was first washed out. The injection remained in only five or six seconds, as it produced intense pain, which could only be controlled by large doses of morphia, hypodermically. The good effects were plainly manifest next day.

This line of treatment is that so highly recommended by Prof. Richardson, in the *Medical News and Library*, of June, 1877.

CHLORALIZED TINCTURE OF IODINE.—Carlos Paves recommends the following as useful in the treatment of large ulcers. It acts both as an antiseptic and a hypnotic:

Pure iodine.....	3ij.
Chloral	3iij.
Alcohol	3ij.

Dissolve, filter, and keep in stoppered bottles.—*Ga. Med. Catalana.*

INFLAMMATION OF THE CIRCUM-ANAL GLANDS.—While operating for piles lately at Soho Square Hospital, Mr. Reeve took the opportunity of demonstrating to the visitors present an affection of the circum-anal glands, which is sometimes mistaken for fistula. These glands become the seat of inflammation, and get overdistended. A probe introduced through the small orifice shows that the cavity burrows for about half an inch in various directions. The best treatment is to slit them up and then touch the exposed surface with nitrate of silver. Curiously this small source of irritation is not described in any of the books on surgery.—*New England Medical Monthly.*

THE TREATMENT OF HEMORRHOIDS BY INJECTIONS OF CARBOLIC ACID.—Dr. Charles B. Kelsey, Surgeon to St. Paul's Infirmary for Diseases of the Rectum, New York, recently opened a discussion of the treatment of hemorrhoids, at a meeting of the New York Clinical Society, by reading a paper on the treatment by injections of carbolic acid. The paper,

which appears in the August number of the *New York Medical Journal and Obstetrical Review*, opens with condensed histories of a number of cases, after which he remarks that, beginning this plan of treatment without very much confidence in it, and with the fear of causing great pain, and, perhaps, dangerous sloughing, constantly before him, the method is constantly growing in favor with him, and the more he practices it the more confidence he gains in it. With solutions of proper strength the danger of causing sloughing of the tumors is very slight. There are no objections to this method which do not apply equally to others. He has once seen considerable ulceration result from it in the hands of another; but he has seen an equal amount follow the application of the ligature; and he does not consider this as a danger greatly to be feared when injections of proper strength are introduced in a proper way. It is applicable to all cases: and may be used where a cutting operation is inadvisable. It acts by setting up an amount of irritation within the tumor which results in an increase of connective tissue, a closure of the vascular loops, and a consequent hardening and decrease in size of the hemorrhoid. Except when sloughing occurs, the tumors are not, therefore, removed, but are rendered inert, so that they no longer either bleed or come down outside of the body. In cases in which the sphincter has become weakened by distension, the injections will also have a decided effect in contracting the anal orifice, as injections of ergot or strychnine do in cases of prolapsus. He has used this method of treatment now many times, and has never, except in one case, had reason to regret using it, or to be dissatisfied with its results, so far as he has been able to follow them. Although slow to advocate any one treatment of this affection to the exclusion of all others, he now generally adopts this from the outset in each case, reserving Allingham's operation for any in which the injections may fail. As yet he has met with no such case. Its advantage over all other methods, provided its results prove equally satisfactory, are manifest. The patient is not terrified at the outset by the prospect of a surgical operation, is not confined to his bed, and is not subjected to any suffering. The cure goes on painlessly, and almost without his consciousness. The method requires some practice and skill in manipulating, in getting a good view of the point to be injected, and in making the injection properly; but this is soon acquired; and he is more and more convinced that the fear of producing ulceration is an exaggerated one, and that when ulceration is produced it is a result either of a solution of too great strength, or of one improperly administered.

ONE HUNDRED CASES OF NEPHRECTOMY.—In our issue for March 11th, we considered somewhat fully the subject of nephrectomy, based on an analysis of seventy-six cases. In the *American Journal of the Medical Sciences*, for July last, Dr. R. P. Harris, with his characteristic thoroughness and fullness, tabulates all the cases that he has discovered on record, 100 in number, of which 50 were done in Germany, 24 in England, and 10 in the United States, besides one case under the care of an American surgeon in China.

These recent statistics show that the total mortality is rather more favorable than was supposed. Excluding those in which the result was doubtful, we reported forty recoveries to 33 deaths—a mortality of 45 per cent. Dr. Harris adds 9 recoveries and 12 deaths, so that it stands 49 to 45—a mortality of 48 per cent. with 6 yet undetermined. Even with this showing, the recoveries from so serious an operation are still over 50 per cent. The lumbar operation, however, has lost its preeminence as to the favorable percentage of recovery. The incision is recorded in 98 cases. Of these 51 are lumbar and 47 abdominal. The results are uncertain in 5 lumbar operations (with a probability of 4 recoveries and 1 death); and in 1 abdominal operation, with a probability of death. Not including the uncertain cases, the abdominal incision shows a mortality of 48 per cent., and the lumbar of 43.5 per cent., as against 60 and 36 per cent. of the earlier table. On the whole, it would seem that in cases of doubt the abdominal incision, preferably that of Langenbuch and Thornton, in the *linea semilunaris*, or the long oblique lumbar incision of Czerny, is the best.—*Phil. Med. News.*

IODOFORM IN ANTISEPTIC SURGERY.—Prof. Lister has made some experiments during the past year with various preparations of eucalyptol, and he is at present testing the suitability of iodoform. Iodoform is chemically nearly related to chloroform, their formulæ differing only in the substitution of the one halogen for the other. Both bodies have powerful antiseptic properties, the addition of less than 1 per cent. of chloroform, for instance, to an animal or vegetable infusion will prevent decomposition for, at least, many months. Iodoform occurs in the form of a dense yellow crystalline powder. Hence it is more convenient than other ordinary antiseptics for the treatment of local sores, for introducing into chronic sinuses, or into scrofulous joints after incision; but it is not easy of application to an amputation or to most other operation wounds; and is quite unsuitable for use with the spray. For this reason,

Prof. Lister still operates under the carbolic acid spray, though he now seems to attach rather less importance to its continuous use, and will stop it, for instance, for a short time during an operation if the cloud it produces be found to interfere with a clear view of the wound. The dressings used consist of cotton wool impregnated with iodoform, and the drug itself is, in certain cases, powdered over the wound from a sprinkling box. "Iodoform wool" has also been extensively used at University College Hospital, and we learn from Mr. Gerard, pharmacist to that hospital, that the great difficulty encountered in preparing the wool is to obtain an even distribution of the iodoform. The desired end is best obtained by treating the powdered drug with ether, in the proportion of about eighty-eight parts of ether to eight of iodoform. In about four pints of this mixture, half a pound of fine clean cotton wool is soaked for a short time; the wool is afterwards placed in a drug-press. About three pints of ether can be squeezed out, and, when dry, the wool contains about 10 per cent. of iodoform. The same objection is made against this wool as against salicylic wool—namely, that its use spreads about the room an irritating dust, with this further disadvantage, that the odor is to most people very offensive. A little glycerine added to the ether used in its preparation checks the former tendency, and the latter drawback is minimized by the addition of eucalyptus oil. The wool ought to be stored in air-tight boxes, and not handled more than necessary before use. It is too early, as yet, to speak decisively of the value of this antiseptic from experience gained in England, but we believe that it has given a good deal of satisfaction to those who have used it, and has proved itself especially valuable in cases where carbolic acid is, either from idiosyncrasy or from the delicate nature of the parts involved, too irritating to be borne.—*British Medical Journal*.

PERMANENT ESOPHAGEAL CATHETERISM.—In cases of stricture of the esophagus from tumors or other causes, the frequency and painfulness of introducing the catheter, together with the danger of injury to the vascular growths, or of making false passages, has led M. Krisbaber, when he has once introduced a catheter, to leave it in the esophagus permanently. In the *Annales des Maladies de l'Oreille du Larynx, etc.*, for November last, he gives the results of his observations on four cases. Evidently it would be very uncomfortable, if not impracticable, to leave a catheter projecting from the mouth. Accordingly he selected the nose as the route to reach the stomach, and then secured the free extremity of the

catheter. If a soft rubber instrument cannot be introduced, he first uses a gum catheter, and after several days removes it and immediately replaces it by one of rubber, at the same sitting, and before its path has had time to become embarrassed.

One would assume, *a priori*, that great discomfort, irritation and even inflammation of the nose, pharynx, esophagus, or possibly even of the larynx, would result, necessitating the removal of the sound; but as a matter of fact, after a few days of slightly painful coryza entire tolerance was established in the parts, to such an extent, indeed, that in the cases reported the tube had remained in place, respectively for 46, 165, 305 and 351 days, and in the last case was still there. We should advise an occasional immediate replacement of such an instrument by a new one, lest the first should become rotten and break.

Milk and other liquid food, and even finely cut meat, can be administered by quite small tubes, and the patient can sometimes swallow liquids to a slight extent, these passing into the stomach by the side of the catheter.

Another important suggestion, already acted upon by Verneuil, is that such a method of catheterism can be used to advantage in other cases, such as ablation of the tongue, resection of the jaw, and in operations on the lips and palate, in which absolute rest of the parts operated upon is required. In such instances, of course, toleration of the catheter should be obtained sometime before the operation. In cases of glosso-labio-laryngeal paralysis, the self-starvation of insanity, in coma, etc., it may also prove of service.—*Phil. Med. News.*

THE RADICAL CURE OF VARICOCELE BY INTRAVENOUS INJECTIONS OF CHLORAL.—Dr. Negretto records (*Gaz. Med. Ital. Prov. Venete*) two cases of varicocele, in which he succeeded in obtaining a speedy and permanent cure by intravenous injections of chloral. In the first case, the patient was aged 28; the varicocele was situated on the left side, turgid, and painful. Dr. Negretto injected, with a Pravaz's syringe, in four different places, a solution of chloral, of seven grains to the ounce. At once, a small, hard knot could be felt in the lumen of the vein. Within a few hours, a mild attack of orchitis supervened, which yielded readily to ordinary remedies. The injection was repeated in one or two other spots, with the same result of again inducing orchitis, which, however, was of the mildest possible type. Six days later, all visible traces, both of the operation and the varicocele, had disappeared. Along the

course of the spermatic vein, a few hard, small, and indolent nuclei could be felt, which corresponded to the seats of the puncture. The author remarks that in this case the obliteration of a few branches of the spermatic vein had evidently been sufficient to effect a cure. The second case occurred in an individual aged 23, in whom varicocele had existed six years. In its leading features it resembled the preceding. Five injections were used, with the result of producing a clot in the vein, followed by slight orchitis, with pains radiating over the pelvis generally. A week after the last operation the cure was complete; and, as the patient never returned, the author believes it was permanent.—*London Medical Record*.

CALCIUM SULPHIDE AS AN ANTISUPPURATIVE.—The committee on restoratives of the Therapeutical Society recently reported to the Medical Society, of the county of New York, on the above subject. The report was based upon 51 cases in which the drug had been used, embracing the following diseases: Pustular acne, chancroidal bubo, furuncle, purulent ophthalmia, otorrhea, suppurative endometritis, axillary abscess, mammary abscess, phlegmonous periarthritis, phlegmon of the neck, hordeolum and bromic acne.

The report contained the following conclusions:

First. In many cases of suppurative affections, ranging from simple pustules of acne to extensive suppuration, certainly an appreciable, often a marked, benefit is derived from the use of calcium sulphide. At the same time the action is not uniform.

Second. The drug is somewhat prone to irritate the stomach, therefore, small doses, frequently repeated, should be used, and one-tenth grain every two hours in acute cases is an average dose, although larger doses may be required. Some patients may bear well one grain three times a day. Patients are more or less annoyed with eructations of sulphuretted hydrogen while taking the drug.—*Medical Record*, April 29, 1882.

SULPHIDE OF CALCIUM IN STRUMOUS OPHTHALMIA.—Dr. Snell speaks very highly of the sulphide of calcium in "strumous ophthalmia," classing under this name, phlyctenular and pustular conjunctivitis and keratitis.

It will be found particularly serviceable in those cases of children with manifest strumous habit, enlarged cervical glands, swollen face, photophobia, and where on opening the eyes a gush of hot tears is emitted, and

examination of the ocular surface discloses one or more phlyctenules on the cornea, or, it may be, merely vascularity of the conjunctiva. These cases, treated by the ordinary constitutional and local remedies, are often tedious, but under the sulphide of calcium, coupled with the usual local application, such as atropine and warm, poppy fomentations, they often quickly recover. The good effects of this remedy are also often conspicuous in other forms of phlyctenular conjunctivitis or keratitis. While he does not look upon the sulphide as a specific in this class of diseases, his experience justifies him in considering it a most useful remedy. The mode of administration is generally in the form of a powder. From one-tenth to one-fourth of a grain of the sulphide, rubbed up with a little sugar of milk, is given three times daily.—*Practitioner*, Jan., 1882.

OBSTETRICS.

ANESTHESIA IN LABOR.—Dr. W. H. Mays, of San Francisco, writes as follows in the *Western Lancet*:

1st. Anesthesia is as necessary in childbirth as in surgical operations.

Pain is, even when viewed scientifically, only a potent evil. Pain is a disease itself, lighting up in the economy its own set of consequences. Unchecked, it goads the nervous system to madness; and pyrexia ensues, with functional and organic disturbances. The whole duty of medicine may be summed up in two requirements: first, to remove pain; second, to prevent it. Opium, which deadens pain, is the most valuable of all drugs; rather than lose it we could afford to part with all the rest of materia medica besides. Chloroform, which also produces insensibility to pain, initiated in its discovery a new era in surgery. Yet there are physicians who, while they never hesitate to prescribe an opiate in cases of severe suffering, who never perform an operation without first anesthetizing the patient, yet will stolidly watch, hour after hour, the agonized throes of a woman, and stretch forth no hand for her relief. The tortures that women often endure in the process of parturition are often beyond conception—at least beyond *our* conception. Take the case of a newly-married girl, gentle, tenderly reared, and fragile as any flower. Of suffering, of endurance, she knows next to nothing; her life has always been shielded by loving care, her wishes gratified, her whims indulged. As is the case with so many American girls, her nervous organization is highly developed, her sympathetic system hypertrophied. She finds herself confronted with childbirth. At the first onset of pain, the little

barrier of fortitude she has built up for the occasion is swept away and she is taken possession of by a terror that her panic-stricken brain fails utterly to control. There is no escape! While one pain is holding her in its terrible grip she knows the next will be yet worse, and the interval is spent in frenzied anticipation of still greater sufferings to come. With nerves strung to a fearful pitch of tension, and reason dethroned by fright, the poor sufferer writhes this way and that, and shrieks in wild despair, "O let me die! I would rather die than endure this."

Throughout this scene the old-fashioned physician preserves an unruffled demeanor, and tries to comfort the wretched sufferer with stereotyped phrases; tells her in pitiful mockery, to "try to rest between the pains;" reminds her, with specious reasoning, that "all women have to go through the same," etc., and withholds in the very acme of physical suffering the blessed unconsciousness that he willingly supplies for the mere drawing of a tooth or lancing of an abscess.

2d. Anesthesia, properly used, does not diminish the force of uterine contraction, but rather promotes labor by lessening the resistance of the parturient canal.

It has been urged against the employment of anesthetics, that it has a tendency to retard labor by diminishing the energy of the uterine and abdominal contraction. I admit the force of this objection when chloroform has been wrongly administered, that is to say, when it has been pushed to profound anesthesia. But chloroform should not be so used except in extreme cases. It is only the slight first stage that is required. If pushed to the third stage, that of complete narcosis, chloroform is abused. It is wonderful how prompt is the calming effect of a little chloroform on a handkerchief. After a few eager whiffs the excitement subsides as if by magic, the shrieks and frantic tossings stop almost instantly, and dreamful ease takes the place of tumultuous misery. The chloroform has not been pushed far enough to stupefy the patient, the contractile efforts return as before, she feels their onset and responds by bearing down, yet goes through it all in half-conscious drowsiness. The cruel tearing pain is vanished, the rebellious muscles yield, the parts distend, and labor is soon a tale that is told. She wakes, if it can be called waking, from what was not sleep but tranquil forgetfulness, to find her trouble over and to rejoice at the cry of her babe. Slight intermittent anesthesia is sufficient to produce all these happy consequences. Never should snoring be produced. It is not insensibility that is to be aimed at, but only a diminution of pain. Administer about a drachm on

a folded handkerchief at each pain, suspending it as soon as the pain has passed. It is a good plan to let the patient hold it herself, as thus deep anesthesia is prevented.

3d. Anesthesia, properly used, lessens the danger of rupture of the perineum.

This follows as a corollary to the preceding. * * * * On this point Fordyce Barker says: "The perineum relaxes and dilates with remarkable rapidity after inhalations of chloroform. Where danger arises from violent uterine contraction anesthesia will save the perineum."

4th. Anesthesia, properly used, has no injurious effect upon the child.

Those who have raised the question of the transmission of narcotic influences to the fetus in utero as a reason for discountenancing the use of chloroform in labor have failed signally in making out a case. Dr. Paul Munde says: "Probably none of us who have frequently administered chloroform in obstetric practice can remember a case where the fetus was the worse for chloroform." Dr. Fordyce Baker testifies: "We know that thousands of women have been kept under anesthetics for hours during labor, and the infant when born has been as active and lively as if no such agent had been used. For more than twenty-five years I have given chloroform to every woman whom I have attended in labor who had sufficient pain to require such relief, and I have never had the slightest reason to suspect that the child was in any way affected by the use of the agent." He goes on to mention one case which he kept profoundly under chloroform for twenty-six hours a woman who had convulsions, and the child when born was perfectly well. Dr. Lusk, of New York, in a list of reasons for caution in the use of chloroform during labor (he does not oppose its use) does not even mention the contingency of danger accruing to the child.

As far as my own experience goes, I never employed anesthesia in labor without profound satisfaction, nor did I ever find it fail to relieve pain and the dread of pain, or to exert a tranquilizing and economizing effect upon the mother. I have had occasion to use it in about one-third of my confinements.

I urge, therefore, in conclusion, that there is nothing to forbid, and everything to commend a more frequent resort to chloroform in childbirth, as much for its moral as for its physical effect. Used with a proper caution, it is by far the most valuable of our aids in the management of labor.

DIAGNOSIS OF OVARIAN CYST BY MEANS OF THE EXAMINATION OF THE CONTENTS.—Dr. Henry Garregues, after a thorough examination of the subject, draws the following conclusions: (*Am. Jour. Obstetrics.*)

1. The examination of the fluid from abdominal tumors affords valuable aid to diagnosis.

2. The *physical characters* give myxoid ovarian fluid in most cases a certain appearance by which it is recognized at once.

3. The *viscosity* is the most important physical character when present; may be wanting in ovarian, and present in non-ovarian fluid.

4. No *chemical* product peculiar to ovarian fluid has been found.

5. The *microscopical* examination is of much greater importance than the physical and chemical (inclusive of spectroscopy).

6. The bodies seen are red blood corpuscles, epithelial cells, nuclei, granules, pigment, finely granular bodies like lymph-corpuscles or colorless blood-corpuscles, pus corpuscles, spindle-shaped cells, colloid masses, cholesterin and indican.

7. The epithelial cells are columnar.

8. Bennett's large corpuscles are epithelial cells in fatty degeneration.

9. Bennett's small corpuscle, Drysdale's "granular ovarian cell," is no cell, but the nucleus of an epithelial cell in a state of fatty degeneration.

10. There is no pathognomonic morphological element in ovarian fluid.

11. The most important element in regard to diagnosis in columnar epithelial cells seen in side view. Their presence excludes all other tumors than those of the ovary, Fallopian tube, and broad ligament (perhaps with the exception of a cyst of the pancreas).

12. Bennett's corpuscles, Drysdale's corpuscles, nuclei with dark granules, and cholesterin have no diagnostic value.

13. Cysts of broad ligament cannot be distinguished from those of the ovary.

14. Neither the quantity, nor the size, nor the shade, nor the arrangement of the elements found in cystic fluid enables us to tell that the cyst is sarcomatous, or carcinomatous, but only that it is ovarian.

The doctor then passes in review the contents of other abdominal cysts, and finally reaches the conclusion that, by studying the physical, chemical and microscopic characters, it is almost always possible to diagnose ovarian cysts, even without knowing anything about the patient, and of course still more so when the result is combined with the other features of the case.—*N. E. Med. Mo.*

II.—4.—4.

MEDICINE.

THE USE OF SALICYLATES IN ACUTE RHEUMATISM.—The discussion of this important subject by the Medical Society of London has been so prolonged and complete as to warrant an extended review of it.

In *The Lancet* of December 24, 1881, p. 1080, is an "Analysis of Statistics illustrating the action of Salicin Compounds in the Treatment of Acute and Sub-acute Rheumatism," by Dr. Francis Warner, assistant physician to the London Hospital and East London Hospital for Children. Tables are given embracing an experience of four years, and these are summarized as follows: In 190 cases in which salicylic acid was employed the average duration of pyrexia was 5.5 days. In 79 cases without salicin, the average was 13.8 days. In 277 cases in which salicin was used the average duration of pain was 5.3 days. In 67 cases without salicin, the average was 9.3 days. In 342 cases with salicin, the average confinement to bed was 19.5 days. In 211 cases without, the average was 23.5 days. In 352 cases with salicin treatment, the average time in hospital was 34.9 days. In 387 cases without it, the average was 36.2 days. From this data, it appears that the salicin treatment has a very great advantage in every respect, and that in the duration of fever and pain, the advantage is more than double. In cases under salicin treatment heart disease developed in 13.6 per cent.; in cases treated otherwise, in 14.9 per cent. Relapses occurred in 33.6 per cent. of the salicin cases, at the average time of 15.2 days, lasting on the average 3.5 days.

In the same journal, an abstract of a paper read by Dr. Owen is given. This embraces 210 cases of acute and sub-acute rheumatism occurring in St. George's Hospital in 1877 and 1878. These cases are carefully tabulated in six sections, and from the analysis thus shown, the following conclusions may be justly drawn: The treatment by salicylates, whether in large, medium or small doses (3, 2 or $1\frac{1}{2}$ drachms per diem), gave an average duration of fever and pain of $3\frac{1}{2}$, 4 and $4\frac{1}{2}$ days; while for cases treated by full doses of alkalies, with or without quinia, the average duration of fever was $6\frac{1}{2}$ days, and of pain 8 days—an advantage for the salicylates of nearly 50 per cent. The duration in hospital was practically the same under all the varieties of treatment. Relapses occurred in about 30 per cent. of the cases treated by salicylates, and in 27.6 per cent of those treated by alkalies, with or without quinia, with an average duration of about 5 days for salicylates, and 2 days for alka-

lies, thus showing a very considerable advantage for the alkaline treatment in this respect. The average days of illness from the commencement of treatment was for salicylates 6.3 days, and for the alkalies 10.3 days. Heart complications were few and the results not significant. Toxic symptoms were seen in a number of cases, all abating when the salicylates were suspended. "No cases of hyperpyrexia occurred, and none ended fatally."

In the same journal, Dr. De Havilland Hall gives statistics based on 54 cases of acute rheumatism treated both with and without salicylate of soda. His conclusions are: "In contrasting the cases—38 in number—treated by the salicylate of soda, it will be noted that their average stay in hospital was less than a day in excess of the average stay of the 16 cases treated without the salicylate, and that in comparing the days of fever and pain, the advantage is still more distinctly in favor of the salicylate plan. In comparing the heart complications which occurred 19 times under observation, the proportion between the two sets of cases is practically the same. This speaks highly in favor of the salicylate plan of treatment, when the much more acute nature of cases subjected to this plan of treatment is borne in mind; but it is only what we should expect from the power the salicylate has of reducing the duration of fever and pain."

In *The Lancet* of Dec. 31, 1881, Dr. Hood, of the West London Hospital, gives the analysis of 1,200 cases treated for acute rheumatism. In the course of the article he says: "I must ask you to refer to Dr. Fagge's table as a basis for comparison, my own salicylate table being simply complementary to his, and I think, as you will see, fully bearing out his statements."

In the same journal, Dr. J. K. Fowler, in comparing his experience at King's College Hospital in 1876, with that at Addenbrooke's Hospital in 1878-79, says: "I have been struck by the comparative absence of severe toxic symptoms at the latter, where the pure acid made from the oil of winter-green is exclusively used." * * * "The advantages claimed for the pure acid are that it rarely produces vomiting and never delirium; so that the treatment can be continued without the necessity of temporarily suspending the administration of the drug." * *

He has submitted specimens of Kolbe's acid for examination, and says: "The analysis is not yet complete, but shows the presence of a considerable quantity of a substance not precipitated by nitrate of silver, and therefore not salicylic acid. This is not an isomeride of salicylic acid;

nor is it carbolic acid. The investigation is of importance, as it may lead to improvements in the process of manufacture and the elimination of the substances causing the toxic symptoms."

In *The Lancet* of January 7, 1882, Dr. Sidney Coupland's contribution to this subject consists in an analysis of 84 cases of acute and sub-acute rheumatism treated with more or less vigor by salicylate of soda. The deduction from his statistics with regard to relapse, is that the withholding of the drug renders the patient more liable to pyrexial and articular relapses than if its administration be continued; but that the relapse may occur in spite of fairly considerable doses being given, as many occurring under doses of sixty grains and upwards for twenty-four hours, as under smaller doses. * * * "Lastly, before leaving this question of relapses, I should like to recall the fact that they may be promoted by a too early transition from a milk to a solid diet, or by too early getting up from bed. The readiness with which the salicylates subdue the fever and pain is liable to lead to too hasty changes in these respects, and therefore indirectly to relapse. I have no figures to bear this out, but I am certain that I have seen relapses occur under the use of salicylate which one might fairly attribute to change of diet or abeyance of rest."

* * * "Salicylate of soda is certainly *anti-pyretic*, and, to a considerable degree, *anti-rheumatic*. That its employment does not appreciably diminish the time necessary to keep the patient at rest more than under other methods of treatment, but that the immense relief given by its use in the abatement of pain and fever—a relief not to be estimated by statistics—renders it by far the most valuable remedy for the disease at present known."

In *The Lancet* of January 14, 1882, Dr. T. J. MacLagan gives a general statistical statement of the results of the treatment of acute rheumatism in 39 of the large provincial hospitals of Great Britain. "The general results obtained in all these hospitals are quite in accordance with those got in the metropolitan hospitals. * * *" Salicin was used in eleven of the thirty-nine hospitals; in two of the eleven it was used to the exclusion of the salicylates. "While the salicylates are frequently said to produce bad effects, not a single reference is made to any bad effects following salicin. In most cases the deleterious effects of the salicylates pass off with the omission of the drug; but to have to omit it is a serious drawback, for its early omission is most likely to be followed by a renewal of the rheumatic symptoms."

In the *British Medical Journal* of January 14, 1882, Dr. P. W.

Latham adds a note explanatory of his previous paper on salicylic acid as a specific in acute rheumatism. He summarizes: "The theory which I hold with regard to the pathology of acute rheumatism resolves itself into the following points: 1. A nervous centre exists, which controls the nutrition of the muscular and other tissues, and which has been termed the 'inhibitory chemical centre.' 2. The action of cold on some individuals, by lowering the power of this centre, modifies the nutrition of the tissues, and leads to the excessive formation of lactic acid and other products. 3. The presence of lactic acid in abnormal amount in the blood produces functional change in the medulla oblongata and the spinal cord (? posterior columns) when brought into contact with them, and develops the local symptoms of acute rheumatism in a manner similar to the production of the symptoms of locomotor ataxy, with its arthropathies, by organic change. 4. If the portion of the medulla in the neighborhood of the origin of the vagus is a point of minimum energy, either hereditary or acquired, according to the particular fibres involved, may cardiac, pulmonary, or pleuritic complications be developed during an attack of rheumatism. 5. Salicylic acid combines with the antecedents of lactic acid, and so prevents its formation. 6. If the administration of the remedy be suspended after the symptoms are relieved, and before the 'inhibitory chemical centre' has recovered its tone, a relapse will certainly take place. Such a theory explains, moreover, the necessity for giving at the commencement, at least, of the treatment as much of the remedy as the system will bear. I hope before long to be able to prove, more conclusively than I did a year ago, the truth of these propositions, and to indicate more accurately the chemical changes which take place in the nutrition, and disintegration of muscular tissue. The object of my note, however, of December 10th, was not to raise a discussion on these points, but to suggest that the effects of the true and the artificial salicylic acids are not identical; and that where the head-symptoms have been alarming, or much gastric or intestinal irritation has been produced, or where the remedy has failed, after the administration of a sufficiently large dose, to give relief, these results were due not to the true acid, but to that artificially prepared, and possibly more or less contaminated with carbolic acid, paraoxybenzoic acid or other impurities."

In the *Lancet* of January 28, 1882, Dr. R. D. Powell expresses his disappointment in the fact that as yet we have "had no records of private practice." * * * * "Hospital records are greatly diminished in value with regard to a question like that of the salicyl treatment of

rheumatism by the facts that, first, in a large proportion of the cases that come before us the attack is not a primary, but a second or a third attack, and it is probable that a considerable number of the cases tabulated should be regarded as *separate attacks* rather than separate cases. * *

* Then, secondly, hospital patients have been ill for some days before coming under our treatment, and have been meanwhile subjected to various treatments, or have suffered from exposure and neglect of treatment. * * *

And, thirdly, a large proportion of the cases both in primary and secondary attacks have already heart complication when admitted." Dr. Powell has "only met with toxic symptoms in the form of delirium or mania in three instances," and as all the cases were treated with salicylate of soda, he thinks "this shows that the complication was not due to impurity of preparation." He further adds: "The value of salicylic compounds in the treatment of rheumatism is well shown in cases outside the ordinary run of acute rheumatism, in which joint symptoms are absent or insignificant, and the disease manifests itself in other unlooked for ways." He then gives two of his own cases corroborating this statement, and concludes his article: "These two cases are the most striking examples I have met with, but I have seen a goodly number of cases of other than joint rheumatism in which the salicylates have proved of value when other measures failed."

In the same journal, important tabular statistics of cardiac complications prior to and subsequent to the introduction of the salicyl compounds, are given by Dr. Smith of the London Hospital. He draws the following conclusion: "That, notwithstanding our expectations, based on the good effect of the salicyl compounds in several of the marked features of rheumatic fever, there is no evidence, so far as hospital statistics are concerned, to show that the introduction of the salicylate treatment has led to any diminution in the amount of cardiac complication in acute rheumatism.

Lastly, in the same journal, Dr. Broadbent, of St. Mary's Hospital, in summing up the discussion of the whole subject, says that he has not been able to determine exactly the numbers, "because the tabular statements have overlapped in some degree, but certainly more than a thousand cases of rheumatic fever treated by salicyl compounds have been under the consideration of the different speakers who have brought the matter before the Society." * * *

And, "If facts can settle a question, then I consider that the value of the salicylic treatment of rheumatic fever may be considered as settled. * * *

I think we may say defi-

nitely that by means of salicylic compounds the duration of the pain and fever in rheumatism is unmistakably lessened: and, even if the stay in hospital is not materially shortened, certainly the suffering is greatly diminished. With regard to relapses, perhaps we may say that they seem to be more common under the new than under the old methods of treatment; still I am quite sure that the explanation of this is to be found in the rapidity with which all the acute symptoms subside under the administration of salicylates. * * * Over and over again I have gone to the bedside of a patient, who has just come out of acute rheumatism, and have found a stream of air pouring down upon the bed, in consequence of the zeal of sisters and nurses for ventilation; and to this fact I am quite certain that many relapses are due. * * * I am not aware that there have been brought forward any illustrations of bad effects which at all neutralize the good results that we have seen. * * * Turning now to another part of the subject, I myself do not—in spite of those most interesting, and of course accurate, tables which have been brought before us by Dr. Gilbert-Smith—believe that the salicylates increase the frequency of heart disease; on the contrary, I quite coincide with the hope and anticipation expressed by Dr. Fagge, in the early part of the discussion, when salicylates are brought to bear upon the fever in the first days of its existence we shall see a notable diminution in the heart disease; for in my experience, during the whole administration of salicylates, it has been exceedingly rare to see heart disease springing up.” He next adds, as a matter of great moment, that his “own very strong opinion is, that it is not merely as dealing with fever that the salicylic compounds act. They have little influence over pyrexia due to other causes than rheumatism. In relieving the fever of typhoid, for example, they are not to be compared with quinine; and, indeed, my own experience of the salicylates in enteric fever has not been favorable. It appears to me that in some way or other the salicyl compounds antagonize the disease rheumatism, whatever it may be.” He then concludes his remarks: “I will not enter now upon the discussion of the various hypotheses which have been advanced as to the nature and cause of rheumatism—that of Dr. Maclagan, for instance, or that of Dr. Latham. I must, however, express my dissent from Dr. Maclagan’s theory, of its malarial origin and bacterial cause, which does not seem to fit in with all the facts in the history of acute rheumatism. Again, I cannot accept the existence of the special chemical co-ordinating centre of Dr. Latham, and I am unable to receive his conclusions drawn therefrom. In saying this I do

not mean to imply that I deny to the nervous system any share in the production of rheumatic fever. I object simply to the establishment of another of those centres which are postulated for anything of which we want an explanation.—*Squibb's Ephemeris*.

WINTER ECZEMA.—There appears to be something in the winter climate, at least of the sea-board States, to cause in many persons a troublesome itching of the surface, generally of the extremities. This itching abates or disappears during mild and moist weather, but recurs with every cold, dry clearing up of the weather. From being slight at first it is apt to increase and become very troublesome, especially upon undressing, and through the night. At this stage vigorous scratching becomes irresistible, and then the surfaces soon become abraded, red and papular with an exudation which sooner or later becomes copious, drying in crusts on some parts, but presenting open ulcerative patches on others. In this stage the itching is replaced by soreness and irritation, and the tendency seems to be to become worse instead of better. By a consideration of the climatic conditions which seem to start and keep up this affection in persons who are otherwise in good health, there seems to be an indication for some agency to keep the surface from becoming too dry—to keep it in dry cold weather in a similar condition to that of mild moist weather. This would be accomplished by a proper use of glycerin. Then there is a very evident indication for an effective astringent to prevent or correct the tendency to the exudation, and such would be found in tannic acid. Add to this a moderate stimulation of the surface to take the place of the scratching in the relief which this gives, and then the indications of the following solution are fulfilled :

Tannic acid, 40 grains; glycerine and alcohol, of each, half a fluid-ounce; water sufficient to make 4 fluidounces.

This solution, applied to the itching surfaces by means of a small sponge or rag, morning and evening, will in a large proportion of cases avert the affection. The itching will be reduced, or will cease altogether, so that scratching can be avoided, and as the other stages arise from the scratching they will fail to occur. If the affection shall have gone on to the stage of irritation and exudation before the solution is resorted to, the solution may then be found to be too strong. Then if diluted with an equal volume of water for a time, until the surface is re-established, it will better serve the purpose, but after this it should be resumed in full strength.

When once the affection is found to be curable in this way, it should never be again allowed to go beyond the beginning of the itching stage before the remedy is applied. After being thus cured once or oftener during a winter, it is apt to recur at the beginning of the next winter and must be watched for. The solution does not keep indefinitely and should be made freshly for each attack.—*Ibid.*

THE SUBCUTANEOUS INJECTION OF ETHER.—It should be more generally known that ether injected subcutaneously has a powerful stimulant effect, and is remarkably efficacious in cases of extreme depression of the powers of life. It has long been used to a limited extent in such cases, but increasing experience has enlarged the domain of its application. In adynamic pneumonia, in fevers when failure of the vital powers is threatened, in the puerperal state, in cases of thrombosis of important vessels, the injection of ether has been lately used with singular benefit. Besides, as a stimulant in conditions of depression, it has important applications as a hypnotic and local anodyne. In cerebral excitement and wakefulness, accompanied by depression of the arterial circulation it is most useful. In the more chronic cases of superficial neuralgia, as sciatica, lumbago, intercostal pain, zoster, etc., injected in the neighborhood of the affected nerves often gives surprising relief.

There are contra-indications to its use. It is not proper in the cases of cardiac depression due to chloroform or ether narcosis, and yet it has, in the confusion incident to such an event, been freely injected on the cessation of the cardiac or respiratory movements. Under similar circumstances, alcohol has also been freely injected subcutaneously, but this practice is equally improper—and both for the obvious reasons that these are synergistic agents. Ether, subcutaneously, is also not a suitable remedy when there is arterial excitement with power.

The technical details are simple. Ether must be injected with a glass or metallic syringe. Rubber and celluloid are damaged by it. As ether dissolves the oil with which the piston is lubricated, the syringe should always be put in order after ether has been injected. It is a useful precaution, also, to see that no particles of dirt or of leather are taken up with the fat. Vaseline appears to be the safest lubricant under these circumstances. From ten to sixty minims is the dose—fifteen minims being the quantity most frequently injected. Some smarting attends the operation, but if the operator is careful in withdrawing the needle to press on the orifice tightly to prevent the ether escaping, much smarting will be

thus obviated. A puffy swelling is caused by the vaporization of the ether, but this presently subsides, and only rarely is an indurated knot formed. An anesthetic and analgesic area of limited extent surrounds the puncture.

The ether used should be of good quality—as good, indeed, as that now employed for inhalation. The number of times injected will depend on the character of the case, but there appears to be no reason why it may not be injected frequently. Three or four times a day has been the rate in cases of adynamic pneumonia. When sudden, extreme depression of the heart is to be overcome, ten or twenty minims can be injected every five minutes, until some result is reached.

The systemic effect is that of a stimulant; the action of the heart is increased, the surface grows warm and the nerve centers and the organs of the body in general functionate more quickly and powerfully. The curative results of the subcutaneous use of ether are not only different in degree, but in kind, from the stomachal administration of the same agent. This fact must be recognized to obtain a correct notion of the utility of this practice.—*Phil. Med. News.*

HOW TO USE FILIX MAS.—The success of certain German “worm doctors” in using extractum filicis led Dietrich to suppose that the best results are obtained when castor oil is administered immediately after the extract, instead of waiting an hour or two, the extract being more likely to reach the worm undecomposed and less likely to irritate the stomach during its rapid passage. Upon experiment this was confirmed (*Pharm. Zeit.*); in fact, the most favorable results were obtained when the extract and oil were administered together. This, according to Herr Dietrich, is most conveniently done in flexible capsules, each containing 1 gramme of extract and 2 grammes of oil. A dose consisting of six such capsules, preceded as usual by a laxative, has been found quite effective.—*Med. Press and Circular.*

REVIEWS AND BOOK NOTICES.

Prices are always inserted when furnished by the publisher, or when obtainable from the bookseller.

The *North American Review* for October opens with an article on "The Coming Revolution in England," by H. M. Hyndman, the English radical leader, giving an instructive account of the agitation now going on among the English working classes for a reconstruction of the whole politico-social fabric of that country. O. B. Frothingham writes of "The Objectionable in Literature," and endeavors to point out the distinction between the literature which is *per se* corrupting, and that which is simply coarse. Dr. Henry Schliemann tells the interesting story of one year's "Discoveries at Troy." Senator John I. Mitchell, of Pennsylvania, treats of the rise and progress of the rule of "Political Bosses." Prof. George L. Vose, of the Massachusetts Institute of Technology, contributes an article of exceptional value on "Safety in Railway Travel"; and Prof. Charles S. Sargent, of the Harvard College Arboretum, contributes an instructive essay on "The Protection of Forests." The *Review* is sold by booksellers and newsdealers generally.

Ten Years' Experience in the Treatment of Stricture of the Urethra, by Electrolysis. By Robert Newman, M. D., of New York.

Dr. Newman has certainly had a pleasant experience in the use of electrolysis in these cases. We heard him lecture on this subject nearly ten years ago, and were much pleased with what he claimed, and seemed, indeed, to demonstrate on a clinical subject. But subsequent experience has not seemed to confirm our high opinion of his method of treatment. We shall, however, give it further trial, on the strength of this article.

"*Leaves of Grass.*" By Walt. Whitman. Philadelphia: Rees Welsh & Co. 1882. Price, \$2.

This is the book about which so much has been written on account of the abandonment of its publication by a Boston firm in consequence of Mr. Anthony Comstock's allegations that it contained objectionable passages. The book contains so much true poetry, so many passages which stamp their author as a true poet of a high order, that it is a pity that Mr. Whitman's own good sense has not moved him long ago to cut out the

"Children of Adam" words and lines, which add nothing at all to the beauty of his work and which are certainly not structural and vital to it. The author of such a poem as "O Captain, My captain," does himself injustice and puts himself at a disadvantage by flying in the face of decent public opinion. Whitman's personality is too sound and clear to be put by a mere piece of injudiciousness, at so great a disadvantage as that under which a few expressions in his poems—wantonly and willfully kept against the advice of his best friends—cause him to labor. He will not expunge them himself, and therefore he must pay the penalty; but after he is dead they will be blotted out of editions, for lovers of the good man will be sure to do for his fame that which he himself has foolishly refused to do for it.

Clinical Lectures on Diseases of the Urinary Organs, By Sir Henry Thompson. Sixth London Edition. Illustrated with seventy-three wood engravings. Philadelphia: P. Blakiston, Son & Co. 1882.

This popular work is printed in pamphlet form by the publisher, and sold at a remarkably low price. The profession is familiar with the general character of the work. The present edition contains some modifications of the older text, notably regarding the subject of lithotripsy. Lithotripsy at a single sitting is regarded as superseding the old operation, and, to a large extent, lithotomy. The book presents an epitome of what is known regarding the diseases of the urinary organs, and their practical treatment.

Syphilis. By V. Cornil, Professor in the Faculty of Medicine of Paris and Physician to the Lourcine Hospital. Translated with notes and additions by J. Henry C. Simes, M. D., Demonstrator of Pathological Histology in the University of Pennsylvania, etc., and J. William White, M. D., Lecturer on Venereal Diseases and Demonstrator of Surgery to the Philadelphia Hospital. With 84 illustrations. Philadelphia: Henry C. Lea's Son & Co. 8vo. Pp. 461. Cloth. Price, \$3.75. Columbus: Geo. W. Gleason.

This work constitutes the lectures of M. Cornil, delivered in the Lourcine Hospital in 1878. The author treats the disease almost entirely from an anatomical standpoint, using the microscope constantly in his study. His observations being made upon tissues removed during life, he was enabled to at once examine the fresh elements, and also to place portions in hardening fluids before they had undergone the slightest cadaveric change. The principal types of the different lesions are then drawn by the aid of the camera lucida. He thinks this is the only proper method

of studying the disease, for the student who understands beforehand all the changes that the epidermis, rete mucosum, papilla, derma and vessels undergo, and how far they extend and in what they consist, will not fail to appreciate the meaning of the symptoms which will then be promptly recognized. There is much new and original matter in the book. The translators have added copious notes, in [], increasing by about one third the size of the book and adding greatly to its value.

Treatise on Human Physiology. By John C. Dalton, M. D., Professor of Physiology and Hygiene in the College of Physicians and Surgeons, New York, etc. Seventh Edition, with 252 illustrations. Philadelphia: Henry C. Lea's Son & Co. 1882. 8vo. Pp. 722. Price, cloth, \$5.50; leather, \$6.50. Columbus: Geo. W. Gleason.

No extended notice of this favorite is needed—would, indeed, be an impertinence. Dr. Dalton has thoroughly revised his work in this edition, and we find in it the results of all the most recent investigations. The changes are particularly noticeable in the chapters on the Nervous System, as research has of late been most active in this department. Much that is new here is in connection with microscopic study. The same is to be said also of the author's treatment of Embryology.

The merits of this book entitle it to be placed in the first rank of the choicest physiological works.

A Manual of Obstetrics. By A. F. A. King, M. D., Professor of Obstetrics and Diseases of women and Children in Medical Department of Columbia University, Washington D. C., and in the University of Vermont, etc. With 58 illustrations. 12mo. Pp. 325. Philadelphia: Henry C. Lea's Son & Co. Columbus: Geo. W. Gleason.

Though this is a small work, it nevertheless contains a very large amount of information on the subject of midwifery. It presents all the main facts of the art, briefly but full enough for all practical purposes. Students in attendance upon medical lectures will find the work of especial value, as it is convenient in its arrangement, clear and concise in expression, and of size adapted to easy use.

The chapter on the Jurisprudence of Midwifery, though unexpected, is one of the most valuable in the book.

The Popular Science Monthly for October, 1882.

The October number is one of great excellence. While all its articles deserve to be well spoken of, several of them are unusually fitted to attract

attention. The first place among this number must be given to the opening article, by Douglas Graham, M. D., on *Massage: its Mode of Application and Effects*, the matter of which is both valuable and novel. Matthew Arnold's *Lecture on Literature and Science*, in which the first place is given to literature in the scheme of education, while science is admitted as a subordinate department of literature, is the next article. A review of the paper, in the editor's table, exposes the utter insufficiency of Mr. Arnold's valuation of science. Dr. Andrew Wilson's *Past and Present of the Cuttle-Fishes*, is full of information about these most curious and varied inhabitants of the deep. Mozley on *Evolution*, is a reply of Mr. Herbert Spencer to some statements in the Rev. T. Mozley's recently published "*Reminiscences*," and is especially valuable because it contains a clear and succinct outline, at first hands, of the whole scheme of the theory of evolution. *Explosions and Explosives*, by Allan D. Brown, of the United States Navy, furnishes accounts of gunpowder, nitro-glycerine, dynamite, and gun-cotton, their properties, and the methods of making and using them. *The Utility of Drunkenness* is found, by Mr. W. Mattieu Williams, to consist in the fact that it promotes "the survival of the fittest" men by furnishing a means, supposed to be agreeable to themselves, of clearing the world of the unfittest. In *Delusions of Doubt*, M. B. Bill, describes a curious mental disease which is sometimes manifested in most remarkable ways. The Annual Address of Professor G. J. Brush, the retiring President of the American Association, on *The Progress of American Mineralogy*, presents an honorable record of the work in that branch of science. In *Industrial Education in the Public Schools*, Professor Straight projects a scheme under which pupils should be turned out prepared to do honest, thorough work as a matter of course. Dr. Felix Oswald lends the unique charm of his keen humor to the discussion of *Physiognomic Curiosities*. *The Formation of Saline Mineral Waters*, by M. Dieulefait, is a suggestive study in chemical geology. *A Partnership of Animal and Plant Life*, by K. Brandt, offers a solution to a biological problem that has caused much perplexity. The Portrait and sketch are of Professor Rudolf Virchow, the physiologist, anthropologist, and advocate of popular rights.

New York: D. Appleton & Co. Fifty cents per number, \$5 per year.

Transactions of the American Gynecological Society. Volume 6. For the year 1881. 8vo Pp. 542. Philadelphia: Henry C. Lea's Son & Co. 1882.

This volume of Transactions is fully up to the previous ones in the value of the papers published in it. Besides the address of President Byford, of Chicago, there are found the following papers, with others: Exporatory Puncture of the Abdomen, by H. J. Garrigues; Pelvic Effusion resulting in Abscess, by G. H. Lyman; Genital Renovation by Kolpostenotomy and Kolpoecpetaisis in Urinary and Fecal Fistules, by Nathan Bozeman; Lupus or Esthiomene of the Vulvo-anal Region, by Isaac E. Taylor; Expansion of the Bladder over Abdominal Tumors, as a Complication of Laparotomy, by T. G. Thomas; Fibroid Polypus with partial Inversion of the Uterus, by Thad. A. Reamy; Jaundice in Pregnancy, by J. W. Underhill; Practice of Gynecology in Ancient Times, by E. W. Jenks.

The papers treat of their respective subjects in a thorough manner, giving the results of the mature experience of the writers, or of their thoughtful study, as well as of the investigations and studies of others.

The work is a valuable one which every Gynecologist may well desire to possess.

What to Do in Cases of Poisoning. By William Murrell, M. D., M. R. C. P., Lecturer on Materia Medica and Therapeutics at Westminster Hospital, etc. Second edition. Detroit, Mich.: George A. Davis, publisher. 1881. Cloth; \$1.

This is a little, 3x4, vest-pocket book, containing a list of poisons most commonly met with, arranged in alphabetical order, each one being accompanied by its appropriate antidote, etc. It makes a very handy little book for reference.

Elements of Chemistry. By Henry Leffman, M. D., Lecturer on Toxicology at Jefferson Medical College; Demonstrator of Chemistry at the Pennsylvania College of Dental Surgery, etc. Philadelphia: E. H. Butler & Co. 1882. 8vo. Pp. 227. Cloth. Price, 84 cents.

This work is intended for the use of students attending college lectures or pursuing the common-school course of study. It begins with a concise, careful and thorough exposition of chemical principles, embracing about fifty pages. This portion of the work is substantially the same as the authors' "First Step in Chemical Principles," a work which has been highly spoken of by reviewers and teachers. Following this essay on principles, is a classified description of the elements and their compounds the space assigned to each being proportioned to its importance.

Abundant explanations of chemical changes are given by means of

symbols, and the arrangement of apparatus is exhibited by means of figures. About one hundred illustrative experiments, requiring only simple apparatus, are described, in addition to a large number of tests and typical reactions. In the organic chemistry the special essays upon "nomenclature" and "radicles" will be found of great advantage to the beginner.

The style of the work is brief but perspicuous, avoiding unnecessary rhetorical ornament, and the disconnected enumeration of facts and figures.

Diseases Peculiar to Women. Clinical Lectures by Lombe Atthill, M. D., Consulting Obstetric Surgeon to the Adelaide Hospital, etc. Fifth Edition. Revised and partly rewritten, with illustrations. Philadelphia: P. Blakison, Son & Co. 1882. Cloth. Pp. 342.

This work is a reprint of the English edition of 1878, and is revised up to that time. The author's claim is to furnish "within the limits of a moderate-sized volume, such an account of the Diseases Peculiar to Women, verified by my personal experience, as would meet their wants," *i. e.*, the wants of practitioners and students. The first lecture describes the method of examining patients. The second is on leucorrhea, vaginitis and vaginismus. The next four lectures treat of the abnormalities of menstruation. The seventh and eighth consider tumors of the uterus. Lectures nine and ten comprise the inflammation of the uterus and vicinity. Lecture eleven is devoted to displacements of the uterus, and lecture twelve to enlargements. Lecture thirteen treats of cancer. Lectures fourteen and fifteen are on ovarian diseases. Lectures sixteen and seventeen are given to uterine therapeutics. There are thirty-five illustrations, mostly of instruments.

It will be perceived that the scope of the work is limited. It does not include all diseases peculiar to women, nor does it treat exhaustively the subjects introduced. The author limits himself to the supposed "wants" of the general practitioner and carefully excludes theoretical pathology and most of the details of modern gynecological surgery. The chief value of the volume consists in the fact that it embodies the experience of the author, and the personal experience of any physician in his specialty is always interesting and should be valuable.

Dr. Atthill excels in his ability to present a clear picture of the diseases in question, in accuracy of diagnosis and adaptation of remedies. He is conservative in mind, though not undervaluing the achievements of

modern gynecology. Practitioners who follow the precepts of this handbook will make few errors. Condign credit is awarded to trans-Atlantic workers in the same field.

The typographical appearance of the book is excellent. G. A. C.

Labor Among Primitive People.—Showing the Development of the Obstetric Science of To-day from the Natural and Instinctive Customs of All Races, Civilized and Savage, Past and Present. By Geo. J. Engleman, A. M., M. D., Professor of Obstetrics in the Post-Graduate School of the Missouri Medical College, etc. Fifty-six Illustrations. St. Louis: J. H. Chambers & Co. 1882. 8vo. Pp. 203. Cloth.

Dr. Engleman has compiled a large amount of statistical information upon labor, as it occurs untrammelled by modern or civilized ideas, which, though somewhat imperfect in arrangement, is extremely interesting and suggestive. He considers the question under the heads of Postures in Labor, The Third Stage of Labor, Parturition and Childbed, and Massage and Expression.

"I have but briefly referred to some of the interesting points to show how similar the practices of Primitive People, past and present, are to our own, and yet although crude how far in advance in many points—in all such in which simpler means, the hands and external manipulations will answer."

From which we may conclude that the obstetric art has not advanced in proportion to civilization, a position which we doubt the author means to assume.

The work will repay perusal as a contribution to ethnology as displayed in the customs of childbirth, a branch of the subject hitherto little investigated. G. A. C.

The Need of Hospitals in Indiana, Constructed and Controlled by State Authority. By Thad. M. Stevens, M. D., Indianapolis.

This is a strong and earnest plea, which ought to bring forth abundant fruits.

The Multum in Parvo Reference and Dose Book. By C. Henri Leonard, M. D. Professor of the Medical and Surgical Diseases of Women, and Clinical Gynecology, Michigan College of Medicine. 34th thousand. Price, in cloth, 75 cents. Detroit, 1882.

This popular little work is on our table. The amount of general information contained in the small volume is astonishing. Its popularity is attested by the fact that thirty-four thousand copies have been issued.

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HANN & ADAIR, Publishers, Columbus.

DRUNK, OR DYING?

This question is asked with more than usual interest in this city just now, since it is only recently that a prominent politician was carried to his room and left there for many hours, by friends who supposed him to be merely drunk, when, in fact, he was suffering from an apoplectic stroke which soon closed his career. Similar cases are being reported constantly in the daily papers, the unfortunates being, however, generally men of less note.

If a man is found unconscious in the street, or becomes so at a convivial party, he is ordinarily either drunk, narcotized from opium, or suffering from cerebral hemorrhage, and the bystanders usually regard themselves as competent to decide which, especially if the breath betrays the presence of liquor or laudanum. But even if a physician is called into the case, it is by no means an easy matter for him always to arrive at a correct and speedy diagnosis, and it is on this account that we propose to briefly discuss the question.

Face and skin: pale and relaxed in opium poisoning, and covered with a clammy sweat; in drunkenness, warm, full and purple, while all the features are more or less swollen and congested. In apoplexy the skin is usually warm, while the face will be pale if the effusion be large, but otherwise ordinarily, flushed and purplish: facial paralysis will be shown by the drawing of the features to one side.

The breathing: in opium narcosis, shallow, sighing in character, and very slow; in drunkenness, full and noisy, apt to be somewhat slow and labored; in apoplexy, full and slow, and accompanied by snoring in inspiration, and flapping of the cheeks.

Pulse: somewhat alike in all three conditions, slow and small; but may be full in apoplexy, and sometimes intermitting.

The pupils: dilated, ordinarily, in drunkenness, strongly contracted in opium poisoning, dilated, and frequently unequal, in apoplexy.

With these symptoms carefully considered, and with due weight given to all attending circumstances, so far as they can be learned, such as the age, clothing, social condition, etc., a correct diagnosis can ordinarily be made. But in case of doubt, as between apoplexy and drunkenness—for opium narcosis can ordinarily be easily enough differentiated, it is certainly much better to express no positive opinion than to make a mistake, while in the mean time the patient can be treated symptomatically on general principles. If an expert chemist is immediately available, some urine may be drawn off and tested for morphia or alcohol, but ordinarily such tests must be limited to determining the presence of albumen. Even if alcohol were found in the urine, this would be merely presumptive proof against apoplexy, and confirmatory of alcoholism.

THE MEDICAL CHRONICLE. Baltimore, Md. Geo. H. Rohe, M. D., Editor. Monthly. Pp. 24. \$1 per annum.

This is a new journal, and comes to us in a neat dress and with attractive matter. It deserves to succeed.

THE INDIANA MEDICAL JOURNAL. Indianapolis. Frank C. Ferguson, M. D., Editor. Semi-monthly. Pp. 32. \$2 per annum.

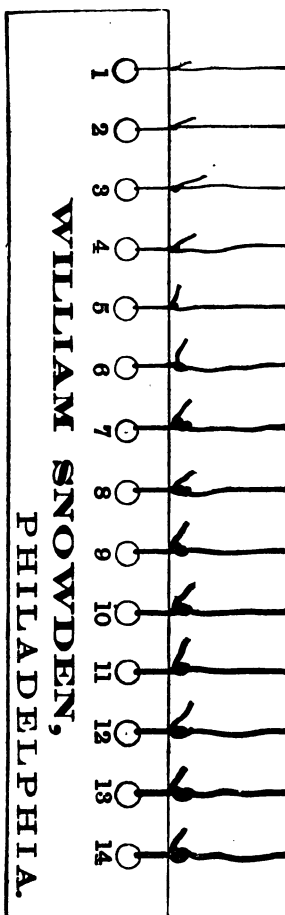
This is another new journal, larger and more pretentious than the former, and unusually pleasing in its make-up and general appearance. It is not hampered with being the organ of any college, and its editor evidently believes in a high standard for college requirements, *and its strict maintenance.*

GROSS'S SYSTEM OF SURGERY.—A new edition of this renowned and popular work, that has become a standard text-book in all parts of the world, has just been completed by its author, the eminent and distinguished surgeon, and is now going through the press.

We are all, as Americans, proud of Professor Gross, and we may well congratulate ourselves that he still retains the vigor and enthusiasm requisite for the systematic revision of such a great work.

NEW INSTRUMENTS.

PURE IRON-DYED SURGICAL SILK.—The subject of sutures has of late years been very largely discussed, and many modifications and additions made in this branch of the surgeon's armamentarium, till the list now embraces



very nearly everything that possibly could serve the purpose of a suture, from gold wire down through lead, iron, silk and catgut, and all their modifications. The objection to the employment of metal sutures has been that they are more painful in removal than those sutures made of softer material, that certain ones of them, when employed in the exposed portions of the body, have at times a tendency to leave their stains in the tissues in which they are imbedded, and that they cannot be accommodated to the size of the eye of the needle with which one may be compelled to work. To meet some of these indications, Prof. Wm. H. Pancoast, of Philadelphia, has recently had prepared a special silk ligature made of the pure silk, dyed with iron, which is fixed in the silk, and then the silk finished with acetic acid. The iron in the silk makes it less irritating in the skin than the white, which is dyed with lead. A fine black ligature, in a plastic operation, will remain a long time without producing irritation, while a white silk of the same size, side by side, will produce inflammation in its track. The black ligature is more easily seen in operations, as it is not discolored by blood, like the white, and in the healing of the wound it can always readily be seen, and is not lost in and discolored by hardened pus so that the surgeon is obliged to hunt in the line of the

wound, or to break it open, to find the ligature. The strong black ligature is particularly good in operating on hemorrhoids, or varicocele, on account of its strength and the little irritation caused by the iron dye, while the finest can be used with great satisfaction in operations on the eye ball.

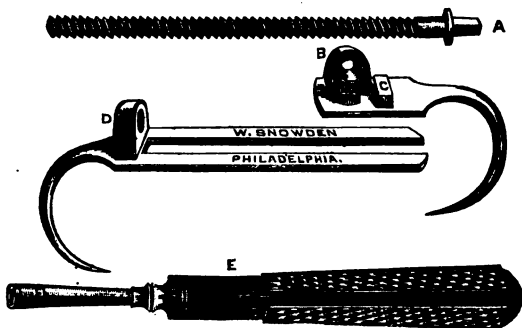
Dr. Pancoast claims to have had much more satisfactory results since using this material than when other agents have been employed, and as he has been experimenting in this matter for the past three years, his conclusions are worthy of consideration. The plate shows the size of the threads and their commercial number, by which they can be ordered.* A sample card will be sent free on application.

MALGAIGNE'S HOOKS, AND THEIR USE.—The treatment of fracture of the patella has always been a stumbling block to the profession. One great trouble has been that in many cases too much has been attempted too soon. This has been especially the case when hooks of various kinds are employed; in no place is the beauty of the advice, "learn to wait," better exemplified than here. Under no circumstances is it advisable to employ hooks until the entire subsidence of the first inflammatory action, and the disappearance of the swelling which takes place immediately after the receipt of the injury. If hooks are introduced during this period, the most lamentable results may be precipitated, not the least of which is erysipelas. The hooks should not be introduced before a week or ten days have elapsed from the time of injury, and not even then if any irritation whatever remains at the seat of injury.

The Malgaigne hook has been for a number of years employed by many surgeons in the treatment of this fracture, and while some have praised others have reviled it. With its construction every surgeon is familiar, the apparatus consisting, as it does, of four hooks, in pairs, each pair being arranged on a sliding frame. While they answer the purpose of holding the fragments of a fractured patella together, they present the disadvantage, which is at times very great, of being applicable only in certain limited positions; while one hook, or the hooks on one side, may be readily and properly fastened, the others must take their chances of securing a proper position. Further, they are made to work together in immovable straight lines, while, primarily, the fact exists that the bone over which they are placed not only presents no straight surfaces, but is decidedly asymmetrical; the result is that it is not always possible to hold properly in position, by Malgaigne's hooks, the fragments of a fractured patella after they are brought into position. Taking all the above facts into consideration, it is evident that more or less modification of the hooks was very desirable, for while in many respects the principle upon which they were founded was admirable, yet in construction they lacked some

*Prices: Nos. 1-8, 20c. per spool; Nos. 9-14, 30c. per spool, post-paid.

of the needful qualifications to adapt them to the work they were intended to do. A number of gentlemen in the profession have made more or less modifications of the hooks, the most recent having been made by Dr. R. J. Levis, of Philadelphia. His modification consists, first, in separating the hooks into two pairs, each of which pairs is again separated, in a manner which we shall describe later. Further, the *ends* of the hooks in this improvement are made decidedly longer, more delicate, and *sharper* (more pointed) than in the original apparatus, this improvement

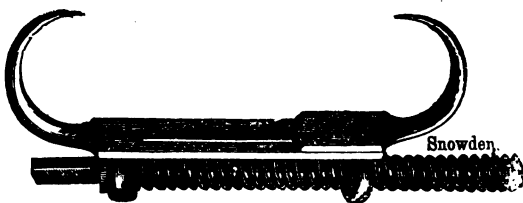


permitting of more easy introduction, as well as affording a deeper and consequently better hold upon whatever structures they may happen to come in contact with; there is, besides, less irritation produced by the presence of these long, comparatively finely-pointed hooks, than by the shorter and more blunt hooks of the original. We shall consider one pair of hooks only, the instrument* being symmetrical on the two sides. A flat bar of steel, two inches in length and half an inch in the transverse diameter, from which a section is cut extending from the stationary screw socket or head to the end of the bar, thus leaving two lateral tongues upon which the movable hook of the apparatus travels; this arrangement is shown in the figure. The permanent screw socket being situated as shown in the cut, just where the hook begins to spring from the body of the instrument, a screw, *A*, which can be tightened or loosened at pleasure by a key, *E*, plays through this screw bed as well as through the eye, *B*. The shoulder, *C*, fits into the tongue portion of the apparatus and prevents all wobbling; while *B*, acting on a pivot, permits the points to be introduced at any distance apart before it is turned into its transverse position and securely fixed by the screw, *A*.

In the next figure the appearance of the apparatus is shown when fixed in position. The result of the arrangement of the hooks in pairs is that they accommodate themselves to any position of the fragments, the movable part being introduced last. Again, by thus dividing

*Wm. Snowden, Philadelphia. Price, \$7.00, post paid.

Malgaigne's hooks into two lateral halves, the pairs may be separately removed and replaced as desired, which is, of course, a desideratum. There has been, we admit, a great deal of objection in many quarters to the employment of hooks of any description in the treatment of patella fractures; but we must pause and ask if many of the failures and unfortunate contretemps reported have not been largely due to the inexperience or haste of those employing them. In this, as in everything else, there is a law which must



be rigidly and unvaryingly adhered to, and this law is altogether in regard to the time of application of the hooks; under no circumstances should the hooks be placed in position before any effusion that has taken place has disappeared, and all swelling subsided, the cases in the meantime being treated as fractures and injuries in other parts of the body and under the same circumstances usually are, any undue overaction or symptoms being combated. Dr. Levis claims that since the employment of these hooks he has seen a number of cases recover, with osseous union, or with such a close coaptation of the fragments as to be indistinguishable from such a desirable result.

NEW BOOKS.

HARLEY ON THE LIVER.—The publishers, Blakiston & Co., announce a new edition of this valuable work, to be illustrated with numerous colored plates and wood engravings. The new edition is promised early in October.

The same publishers also announce cheap editions of the following standard works: Tilt, on Change of Life in Women; Beale, on Slight Ailments; Allingham, Diseases of the Rectum; Acton, on the Reproductive Organs; James, on Sore Throat; Day, on Headache; Heath's Manual of Minor Surgery and Bandaging; and Heath's Surgical Diagnosis.

These are all new and revised editions, are printed on good paper, with clear and distinct type, contain all the illustrations of the original editions, are neatly bound in both paper and cloth, and are sold, in paper, at 75 cents, and cloth, \$1.25 each, post paid. This is certainly the day of cheap books.

NOTES AND COMMENTS.

TO REMOVE BAD ODORS FROM THE HANDS after post-mortem examinations, etc.. use a one-half per cent. solution of permanganate of potash; this stains the hands black, for which use a 10 per cent. solution of dilute hydrochloric acid.

A common German criticism on English physicians is, that men of distinguished reputations are not to be found in hospitals, but cultivate the *praxis aurea*. The greatest men do not find time to teach, and this fact must react on the interest in London as a medical center.—*British Medical Journal*.

A REMARKABLE FACT.—The only medical colleges in New York which require students applying for graduation to be examined by Boards independent of the teaching faculties, are the Woman's Medical College and the New York Homeopathic College!

Dr. L. P. Vandell says: "It was declared a century ago by John Hunter 'that there are but three classes of skin diseases; one of which is cured by mercury and the iodides, a second by sulphur, and a third class which the devil himself can't cure.'" Hunter was evidently well informed.

GENIUS, MONEY, SKILL AND LABOR.—Tennyson can take a worthless sheet of paper, and by writing a poem on it make it worth \$5,000. That's genius. Mr. Vanderbilt can write fewer words on a similar sheet and make it worth \$50,000,000. That's capital. The mechanic can take material worth 5 cents, and make it worth \$100. That's skill. The ditch-digger works ten hours a day, and shovels out three or four tons of earth for \$1. That's labor.

The first instance where physicians are mentioned in the Bible is 2 Chronicles 16: 12: "And Asa, in the thirty-ninth year of his reign, was diseased in his feet until the disease was exceedingly great; yet in his disease he sought not the Lord, but the physicians. *And Asa slept with his Fathers.*"

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No. 5.

COMMUNICATIONS.

IMPACTED FRACTURE OF THE NECK OF THE FEMUR, WITH INVERSION OF THE FOOT.

BY W. J. CONKLIN, M. D., OF DAYTON, OHIO.

Professor of Diseases of Children in Starling Medical College.

Mrs. F., aged 84, a large and fleshy but feeble woman, in attempting to use the vessel on the night of July 5, 1882, fell and injured her left hip. As nearly as could be ascertained, she fell backward and to the left, striking upon the great trochanter. She was unable to move without assistance, but under the impression that it was only a bruise, domestic remedies were applied for a few days after the accident.

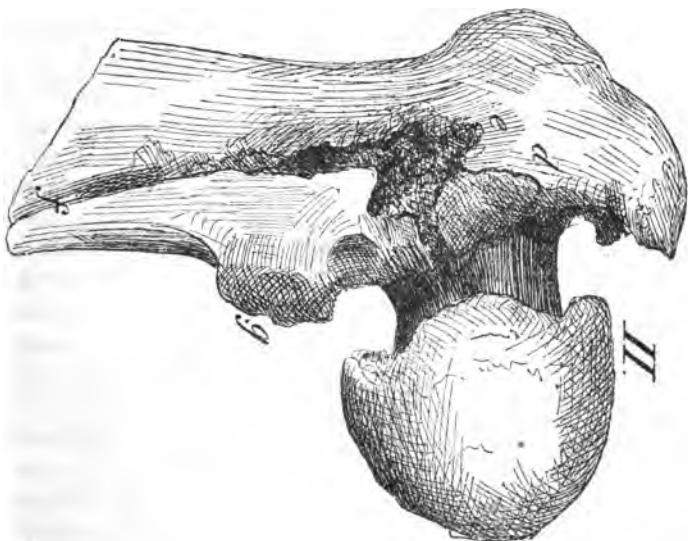
When visited by me, she was in bed with the limb slightly flexed, rotated inwards, so that the patella faced the opposite thigh, and shortened to the extent of one inch. The position of the limb at once suggested a dislocation upon the dorsum ilii. A careful examination, however, showed that the head of the bone clearly rotated in the acetabulum, and that the trochanter moved with it. The left trochanter was distinctly nearer the anterior superior spinous process of the ilium than the right. Pain was caused by pressure over the trochanteric region, which seemed somewhat thicker than on the opposite side. Gentle traction had no effect in overcoming the shortening; moderate flexion gave but little pain. Crepitus was not obtained. An impacted fracture of the neck of the femur was diagnosed, and all manipulative efforts discontinued. She

lingered for four weeks after the accident, and finally died from exhaustion. The inversion of the foot remained constant during the progress of the case.

Assisted by Drs. Jewett and Sperry, I made a post mortem examination, and obtained the specimen figured in the accompanying plate. When the specimen was placed in the hands of the artist the fact that the impaction had been partially released was unfortunately overlooked, and hence the drawings represent the neck considerably longer and the head less depressed than in the original. As is usual in impacted fractures of the neck of the femur, the line of separation at the base corresponds with the anterior and posterior intertrochanteric ridges. In the specimen before us the whole neck is strongly driven into the cancellated tissue of the trochanteric fragment, and forms somewhat less than a right angle with the shaft. The principal fracture on the anterior surface follows the intertrochanteric line to its termination in the *linea aspera* (f) about one inch and a half below the lesser trochanter; the neck is driven in so as to leave a fissure, about one-quarter of an inch in width, between it and the anterior wall. A small fissure (b a) begins immediately above the tubercle and extends almost horizontally across the greater trochanter for a distance of one inch and a quarter. The principal fracture on the posterior surface corresponds with the posterior intertrochanteric line. The lesser trochanter is broken off and twisted inwards and forwards, evidently by the force of the impaction; the fracture communicates with that on the anterior surface. The tilting forward of this fragment leaves an irregular gap (e) of more than an inch, at its greatest width, through which the impacted neck can be seen approaching the posterior surface and almost reaching the outer wall of the shaft. A narrow fissure (d) runs from the upper margin of this gap along the great trochanter. The head of the femur is somewhat roughened, and an irregular collar of bone projects from the greater portion of the corona, evidently the result of chronic arthritis.

Examples of this accident are of very infrequent occurrence. Profs. R. W. Smith, Bigelow and Hamilton, have each met with but one case.

There are few injuries of greater practical interest to the physician than those of the hip. Occurring with comparative frequency, usually difficult of diagnosis, and far too often unfortunate in result to both physician and patient, every case, in which the exact lesion is determined by a post mortem examination, is invested with intense medico-legal as well as clinical importance; more especially is this true when the case pre-



Anterior Surface. II. Posterior Surface. (Reduced one-half.)

sents symptoms which are anomalous. We recall a recent malpractice suit, instituted several years after treatment of the injury, in which had inversion been present the practitioner would, beyond doubt, have been heavily mulcted in damages, so closely did the results of an undoubted impacted fracture of the neck of the femur simulate a dislocation upon the dorsum ili. In commenting upon the case just reported, we propose to confine our remarks to the causes which determine the position of the foot in fractures of the neck of the femur.

In fractures of this region, whether within or without the capsular ligament, simple or impacted, the limb is almost invariably everted, the degree varying from a slight outward inclination to complete eversion, in which the foot rests upon its outer border. There is, by no means, perfect unanimity of opinion among surgeons as to the causes which produce this external rotation. Sir Astley Cooper attributed it to the action of the external rotator muscles which are inserted into the trochanteric fossa, and this explanation has been generally adopted by the profession. Later investigations, however, while showing muscular action to be a factor in the causation, prove conclusively that the deformity results almost wholly from the weight of the limb and its natural tendency, when undisturbed, to rotate outward. In the impacted fracture another factor is introduced, upon which Bryant, Bigelow and others lay great stress, namely, the peculiar anatomical formation of the neck of the femur, by which the cortical structure on the posterior aspect is thinner and more friable than that on the anterior aspect. This difference is more pronounced at the base of the cervix, where the posterior wall becomes almost as thin as paper when it is reflected over the trochanter. In the ordinary impacted fracture, the thin posterior wall is alone driven into the cancellous tissue of the shaft, while the thick anterior wall yields only partially and thus forms a hinge upon which the shaft rotates outwards; thus the arrangement of the bony tissues at once "invites and explains the eversion."

It has long been known that in very exceptional cases of all the recognized forms of fracture of the neck of the femur, the foot may retain its natural position or be inverted. Pare, I believe, was the first to describe a case of this accident accompanied with inversion. Various hypotheses have, from time to time, been advanced to explain the anomalous positions of the limb, of which examples are so rare that it is not given to any one person to solve the problem out of the richness of his own clinical observation.

The greatest difficulty has always been experienced in accounting for

inversion of the foot in *simple intra-capsular fractures*. Mr. Guthrie (*Medico-Chir. Trans.*, Vol. 13,) even makes the statement, "that inversion of the foot does not take place in fracture within the capsule," but numerous cases verified by post mortem examination place their occasional occurrence beyond doubt. Mr. Langstaff (*Med. Chir. Trans.*, Vol. 13., Part 2,) reports an interesting case in which there was at first eversion, but subsequently persistent inversion of the toes. The specimen showed a fracture through the base of the cervix (within the capsule), and a second one between the trochanters.

In the *impacted intra-capsular fracture*, which, for evident reasons, must be excessively rare, the causes producing inversion are very similar to those operating in the more common extra-capsular impaction, which will be presently discussed. In simple intra-capsular fractures, it is certainly reasonable to suppose that the fixation of the limb in the inverted position in which it has been driven by the fracturing force, may be caused either by the upper end of the lower fragment becoming imprisoned in a rent in the capsule, or by projecting spiculæ of bone penetrating the fibrous covering of the neck or the capsular ligament.

In the *impacted fracture of the base of the neck* (extra-capsular), Dr. Bigelow (*The Hip*, 1869) finds the explanation of the inversion in the anatomical formation of the neck, to which allusion has already been made. In describing his case, he says: "The inversion was due to the extent of the comminution, which had separated the walls of the shaft so as to receive in the interval the whole neck, instead of the posterior wall only, as commonly occurs, thus producing an anterior as well as posterior impaction."

Dr. Smith's case, as also the one herein reported, offers strong confirmation of the truth of this theory, but Dr. Bigelow himself refers to a specimen in the Mutter Museum, in Philadelphia, in which a similar impaction shows neither inversion nor eversion. We are firmly convinced that the position of the limb, in a given impaction, depends upon its position at the moment the injury is received, and the direction in which the force is applied. However, that the peculiar construction of the neck is an important factor in the causation must be evident to any one who will closely observe the bone. We can hardly conceive of inversion taking place without impaction of the anterior wall of the cervix, but, as the museum specimen already alluded to shows, anterior impaction is not always attended with inversion.

The *unimpacted or simple extra-capsular fracture of the neck* furnish-

es the largest number of examples of inversion. In fifteen cases recorded by R. W. Smith (*Treatise on Fractures in the Vicinity of Joints*, 1850), the foot was inverted in three, or twenty per cent.; this percentage is larger than is given by any modern writer.*

It is now generally conceded that, with rare exceptions, all extra-capsular fractures of the neck are primarily impacted, and when the opposite condition is present the impaction has been overcome by excessive comminution of the trochanteric region, by a second fall, by muscular action, or by the manipulations of the surgeon.

Various causes have been assigned for the inversion in this form of fracture. Prof. Smith believes it to be due to the circumstance that the inferior is always found in front of the superior fragment. He states: "This position of the lower fragment would, probably, render the pectineus and superior portion of the adductor magnus rotators inwards, while at the same time, the position of the superior fragment behind the inferior presents a mechanical obstacle to rotation outwards, the tendency to which is further prevented by the diminution in the power of the small rotator muscles of the hip, consequent upon the fracture of the trochanter. If the lower fragment be so far displaced forward as to bring the insertion of the pectineus and upper portions of the adductors in front of their origin, these muscles would, probably, become rotators inwards, or, at all events, their power of rotating outwards would be lessened" (*loc. cit.*, p. 29).

As remarked by Mr. Erichsen, this position of the lower fragment is rather the result than the cause of the inversion. The weight of authority is, however, strongly in favor of recognizing muscular action as the prime factor in producing the inward rotation of the injured limb. Mr. Erichsen (*System of Surgery*, 1877,) is disposed to attribute the inversion, in some cases at least, to the external rotators being paralysed by the violence that occasions the fracture, and thus the adductors acting without antagonists draw the thigh and leg inwards. Mr. Guthrie (*loc. cit.*, p. 112,) teaches: "When the fracture has taken place in such a manner as to be external to the insertion of the rotators outwards, and yet sufficiently within the insertion of the gluteus medius and minimus, the toe will be turned inwards, and must always be so; or remain without any alteration of position, according to certain variations in the inclination of the fracture affecting the power of these muscles." It has,

*Dessault met with inversion in fractures of the femoral neck so often as to compute the frequency of its occurrence to be as one to four—most certainly a remarkable statement.

however, been objected to this solution, that if the fracture took the precise course described above, the adductor muscles and the pectineus would be more than sufficient to counteract the group of internal rotators. But there is by no means such great disparity of power, between the internal and external rotator muscles, as this objection would imply; the truth of this statement can be readily substantiated by any one who chooses to make the simple experiment. In fact, Mr. Owen, in a paper read before the British Medical Association (*Medical Record*, 1879,) claims to have experimentally proven that the muscles of internal rotation are really more powerful than those of external rotation.

But it seems to us that the most serious objection to the theory of muscular action is, that it proves too much. If this be the correct explanation, then inversion should be the rule in these fractures, instead of the rare exception, since the pathological condition in the vast majority of simple extra-capsular fractures is precisely that described as essential to the theory. In this accident, the impacted neck acting as a wedge either splinters or completely detaches one or both trochanters, and, in fact, extensively comminutes the whole upper region of the shaft; hence, very frequently the action of the external rotators can only be on detached fragments, leaving the internal rotators unantagonized. Prof. Smith makes the important statement that in those fractures accompanied by inversion, when the deformity has been removed and the limb restored to its natural length by extension, as soon as the extending force ceases to act, though the limb is again shortened, the foot will remain permanently everted (*loc. cit.*, 25.). The conclusion then seems to be irresistible that in the unimpacted extra-capsular fracture, the inversion is the result of direct force applied to the trochanter when the limb is rotated inwards, and that this position is maintained by a peculiar interlocking of the fragments.

While it is difficult with our present knowledge to frame a law applicable alike to all cases of fracture of the neck of the femur with inversion, it is highly probable that the anomalous position of the foot depends upon the direction in which the fracturing force is applied, and the position of the limb at the moment of its application, while fixation is secured by means varying in each group of cases, if not, indeed, in each individual case.

THE RADICAL CURE OF HIP-JOINT DISEASE.

BY REUBEN A. VANCE, M. D., CLEVELAND, O.,

Professor of Operative Surgery and Clinical Surgery in the Medical Department of the
University of Wooster; Consulting Surgeon to Charity Hospital; Honorary
Member of the Cincinnati Academy of Medicine; etc.

*Extracts from a Lecture delivered at the Joint Session of the N. E. O., and the N. C. O.
Medical Associations, Akron, Ohio, 1882.*

In introducing the subject of "The Radical Cure of Hip-Joint Disease," I do so, well knowing that in order to state my conscientious convictions, I shall have to enunciate principles diametrically opposed to those advanced by the leading authorities on articular affections. Educated under the eye of one who to-day enjoys a world-wide reputation in this branch of Surgery, it would be far more agreeable for me to dilate upon the acknowledged skill of this admirable surgeon, than to place myself in opposition to him. For years his faithful follower, and as a medical teacher the zealous exponent of his peculiar views, it was only when I could no longer blind my eyes to the connection between the measures adopted and the unsuccessful results I attained, that I ventured to test the sufficiency of his principles and the merits of his practice. Then I saw, but too clearly, how incorrect was the pathology I had believed in, and how erroneous the treatment I had adopted.

Hip-joint disease commences in inflammation either of the joint, or of the osseous tissue near the articulation—occasionally in both. These lesions are readily curable. The hip-joint, like every other articulation in health, is admirably fitted for the performance of its function—the resistance of pressure and the facilitation of motion. With disease of the hip comes inability to perform its normal offices; motion and pressure are as much restrained by voluntary effort as by reflex muscular contraction. If the joint be in any way moved, the nerves in and near the articulation are irritated, and irregular but powerful muscular movements are evoked. These muscular contractions force the diseased articular surfaces together and give to the extremity various characteristic positions. In a few cases synovitis of the hip-joint, or osteitis near the articulation, recovers spontaneously. In these cases one fact is always apparent: The joint is kept motionless with the leg and thigh fixed in one position—in these patients there is no muscular spasm, and none of the phenomena so common in cases where motion of the joint is permitted. If motion be permitted at

the diseased joint, the evidences of synovial inflammation or bone disease are speedily supplemented by muscular spasm and excruciating pain. The various groups of muscles that unite the extremity to the trunk are called into action; the thigh is fixed in one position and flexed on the pelvis; and the head of the femur is violently forced against the upper and back part of its socket. With sleep comes an interruption of the control previously exercised over this part; spasmodic, intermittent contractions ensue, and develop the night pains so characteristic of progressive disease of the joint. In this way motion and pressure produce absorption of the opposed surfaces and cause purulent arthritis. Unfortunately, the foregoing phenomena are not limited to cases of morbus coxarius, running an unrestrained course—they may attend any case of hip-joint disease, during the treatment of which motion is permitted at the hip-joint.

Professor Louis A. Sayre has identified himself with a system of articular therapeutics, in which motion of the inflamed joint surfaces, during treatment, is a cardinal principle, and his extensive attainments, great reputation and known ability have caused this system to be adopted not only by the medical men of his own country, but by the profession in almost all parts of the civilized world. In view of this fact, I would ask you to consider Sayre's pathology of hip-joint disease before reviewing the treatment he advises for this affection:

Professor Sayre divides hip diseases into three stages: one of irritation; a second of effusion; and a third of rupture of the capsule. In the first stage he says there is lameness, with flexure of thigh on pelvis; in the second, the capsule is distended with fluid, and, as a consequence of this distension, the limb is flexed, abducted, everted and apparently lengthened; while in the third, the capsule having ulcerated, or the acetabulum become perforated, the fluid is either effused into the tissues of the thigh, or discharged into the plevic cavity—the limb at once becoming adducted, inverted and apparently shortened. Here certain positions of the extremity are ascribed to given anatomical conditions of the hip-joint. Is this correct? I say, most emphatically, that it is erroneous—that these different positions are not due to the presence or absence of fluid in the hip-joint, but are wholly due to the influence of irritated nerves acting upon powerful muscles surrounding the upper end of the thigh. How can you test the truth of my statement? Readily enough: by aspirating a distended hip-joint, the exact condition is produced that Sayre declares to be the essential element in converting his second into his third stage of hip-joint disease. If Sayre is correct, by aspirating the distended joint

the abducted, flexed, everted and lengthened extremity of his second stage should instantly become the adducted, flexed, inverted and shortened limb of his third stage. But in my hands aspiration has been demanded for the relief of a distended hip-joint, when the limb was flexed and everted, without causing any change in the position of the extremity; and, finally, I have resorted to it for the purpose of removing fluid from the hip-joint of a patient whose thigh was flexed, adducted and inverted. In view of these facts—and, fortunately, they are such that any surgeon can test their accuracy himself—I am compelled to pronounce Professor Louis A. Sayre's explanation of the mechanism of the physical phenomena of hip-joint disease demonstrably untrue, and his division of the stages of the affection contrary to the plain facts of Nature!

Every attentive student of pathology is aware that the joint structures of the body in health are non-sensitive; in disease, however, they are exquisitely sensitive. In health they are adapted for motion, and can withstand pressure; when inflamed the slightest movement induces excruciating pain. When a joint becomes diseased, Nature exerts all her powers to keep that joint absolutely motionless. The only machinery at her command is the muscles; these contract and hold the limb firm and the joint still. The position the limb assumes depends upon the relative strength of the various groups of muscles, and the extent to which the joint is implicated. A knowledge of these few facts furnishes invaluable aid in both diagnosis and treatment. By observing the course of cases in which no treatment—or what is exactly the same, a treatment that permits the joint surfaces to move upon each other—is adopted, it is seen that the joint becomes more and more flexed; that, up to a certain period, the angle of flexion corresponds with the duration of the disease; and that, although the apparent shortening and lengthening are due to the groups of muscles called into action, and the period they continue contracted, still it can be stated, as a fact of observation, that flexion of the thigh upon the abdomen, slight adduction, and eversion accompany apparent lengthening of the extremity, and precede marked adduction, inversion and apparent shortening, just as in the order of clinical phenomena, apparent shortening precedes real shortening.

The Diagnosis of Hip Disease, after it has persisted for a length of time, is a very simple affair. Its recognition in an early stage is occasionally a difficult problem. It is a matter of vital moment to the patient to have the disease recognized early in its course, for in the hands of surgeons, guided by true principles, its cure is then a certain and simple matter. Fortunately,

the rules for diagnosis are as easy of application, and as sure of success, as the principles of treatment are fixed and immutable. The manner in which the surgeon should proceed is as follows: Strip the patient, and place him flat on his back on a hard table covered with a sheet. Arrange him so that the line which marks the junction of knees and feet, when the lower extremities are extended and in contact, if drawn upwards should bisect symphysis, navel and sternum; then, if one limb be flexed more than another, elevate the knee of the latter until both knees are together, and the two feet side by side. This done, note the position of the lumbar spine, and observe the effect of alternately depressing each knee until its popliteal space is in contact with the table, while its fellow remains flexed. The knee on the healthy side can be depressed without increasing the space between the spine and the table, but whenever the knee corresponding with the diseased hip is depressed the lumbar spine curves, and makes the space between it and the table the greater. This points out the site of disease, and indicates beyond question the hip affected. Then the surgeon grasps the healthy limb and flexes it so that the knee is in contact with the chest—this places the sacrum, the lumbar spine and back of the chest in the same line; while this position is maintained, the patient is urged to extend to the utmost the diseased limb—this he will be able to do in exact proportion to the length of time the disease has lasted, provided it has not been in existence more than one year. The angle the partially flexed extremity makes with the longitudinal axis of the body is a very important one, inasmuch as by simply measuring it the surgeon can approximate with great accuracy the course of the affection, and estimate with precision the duration of the malady.*

While Nature aims to fix the joint and hold it as nearly motionless as possible—a procedure that effects a cure in a small minority of cases, it matters not what the surgeon does so he leaves the part at rest—yet the

*The following table, based upon the researches of Thomas, of Liverpool, and supplemented by certain observations of my own, is inserted in order that the reader may have a true idea of the close relation that subsists between the duration of the disease and the extent of the angle above described. Thus:

An Angle of 170° denotes the disease of about 6 weeks duration.								
"	"	"	160°	"	"	"	"	3 months
"	"	"	150°	"	"	"	"	4 "
"	"	"	140°	"	"	"	"	5 "
"	"	"	130°	"	"	"	"	6 "
"	"	"	120°	"	"	"	"	7 "
"	"	"	110°	"	"	"	"	8 "
"	"	"	100°	"	"	"	"	9 "

advantage gained is complicated, to a perilous degree, by dangers arising from the pressure together of the diseased surfaces. Nature strives to fix and hold in one position the diseased surfaces; the only mechanism at her command consists of groups of muscles varying in power and relative excitability, and agreeing in but one thing—in the degree of force with which they can make the femur press against the acetabulum. Consequently the longer Nature, unaided, is permitted to contend against synovitis, or ostitis and synovitis of the hip, the more will the articulation suffer, and the greater the danger of caries and prolonged suppuration. Until the joint gives way before the powerful compression of the irritated muscles—a lesion readily explicable when the influence of local inflammation is added to the effect of absorption from constant pressure—the position of the extremity will depend upon the comparative power of the opposing groups of muscles. Experience shows that for the first nine months the thigh becomes more and more flexed upon the plevis; that the area of greatest disease passes from above gradually downward over the posterior superior quadrant of the circle of the acetabulum.

Nature here, as in so many other regions of the body, plainly indicates the character of the treatment that must be adopted to secure success. Let the surgeon do what Nature is vainly trying to do—fix the limb firmly in whatever position it chances to occupy—and at once all irregular muscular action ceases. With efficient fixation comes a tendency to extension of the thigh, for it is kept flexed by but two agencies, the action of the muscles and the ensheathing-callus-like influence of inflammatory exudation about the joint, and in a few days, with little effort, and no pain, the thigh is brought into line with the body and the extremity straightened. This done, but one other thing is needed for a radical cure; that is, to give the diseased part rest until resolution occurs. Fixation of the extremity and rest of the inflamed parts, are the principles upon which Nature cures hip-joint disease. Motion of the joint, by irritating the diseased surfaces, not only prevents repair, but by evoking excessive muscular action, may cause destruction of the articular structures.

How fare the various popular systems of treatment for hip-joint disease, when brought to the bar of Nature and tested by Nature's principles? Look at the hip-joint appliances known by the names of Davis, Sayre, Bauer, Hutchinson, Andrews, or Taylor. The splints devised by these surgeons are all designed to favor that which Nature strives to check—motion at the hip. How is it with extension by weight and pulley, the foot of the bed being elevated and the weight of the body acting as a

counter-extending force? Nothing could thwart Nature more effectually unless it be the above splints; the latter permit the diseased surfaces to move, thus exciting muscular spasm; the former acts directly upon the muscles and evokes reflex contractions; in both, Nature's endeavor to fix the joint is foiled. In one respect extension by weight and pulley is less disastrous than splints permitting motion—the application of the former necessitates confinement to bed, and despite the injury arising from constant stimulation of the muscles, the recumbent posture and incidental rest in a measure counteract the harm done. In so far as the popular mechanical treatment of the day permits motion at the hip, or employs extension, its effect is injurious to the patient. The appliance of greatest benefit to the patient is one that fixes the extremity and holds the joint motionless.. *What a diseased joint wants is just what a fractured bone needs*—EFFICIENT, ENFORCED and SUFFICIENT REST!

This all-important rest can be obtained for the hip by appliances based upon the principle of either lateral fixation, or posterior fixation—preferably the latter. In apportioning apparatus to an extremity, and determining the kind of fixation and the degree of rest necessary for the cure of hip-joint disease, each case must be judged upon its own merits. Take a patient with morbus coxarius at any stage, and treat him upon the principle just set forth, and he will recover with a rapidity unknown to any other method. Not only that: this treatment will cure patients whose cases will resist all other therapeutical procedures.

In order to secure such results, certain details that can only be briefly alluded to here, must be carefully attended to. If the synovial cavity contains fluid, it must be removed; if the leg is flexed on the thigh and the thigh on the body, the deformity must be relieved; and, finally, the fixation must be maintained and the rest continued, not only until all tenderness disappears and all inflammation subsides, but until all the callus-like induration about the joint has been absorbed. In order to dispose of fluids that accumulate in the joint, the aspirator can be resorted to. There is but one rule to guide the surgeon in this matter; the joint is to be kept free from liquid effusions, and the aspirator should be used sufficiently often to attain this end. The influence of reflex muscular contraction in producing the deformity characteristic of this affection has been sufficiently dwelt upon; the surgeon who will apply a posterior fixation splint to one of these extreme cases, will have an opportunity of noting the fact that, *so soon as his apparatus relieves the tense muscles* THE WEIGHT OF THE LIMB AT ONCE TENDS TO STRAIGHTEN THE EXTREMITY

AND RELIEVE THE DEFORMITY. If his splint is one that can be moulded to the part as the extremity extends itself, no other influence than fixation and rest will be required to restore the parts to an extended position. The joint freed from effusion and the limb relieved of deformity, the posterior fixation appliance should be worn by the patient until all pain has disappeared from the joint. The recumbent posture that the patient assumed when the apparatus was first applied, and which has been continuously maintained thus far, should not be deviated from until no reasonable amount of manipulation of the diseased articulation excites pain in or around the joint. When this state has been attained the splint can be removed, but the patient should still keep his bed. It will frequently happen that even after the joint has recovered, a certain amount of the inflammatory induration—one of Nature's conservative provisions to limit motion in cases of articular disease—early effused, still remains and demands the stimulus incident to commencing motion of the joint for its absorption. If the joint has recovered, a few weeks of recumbency without fixation-splint suffices for the removal of the induration about the joint and the restoration of motion at the hip. Should the induration persist, or should it disappear without the articulation recovering its freedom of motion, *more or less disease of the joint remains and the splint should be reapplied.*

Above all things, do not call this "Fibrous Anchylosis," or "False Anchylosis," and try to cure it by passive motion. As well endeavor to cure vascular keratitis by putting sand in the eye! The "stiff" joint that follows articular inflammation is an uncured joint, and the only true method of relief is to reapply your fixation-splint, and give it that rest which Nature demands as the condition of its cure.

THE HIGHER EDUCATION OF MEDICAL MEN.

BY H. J. SHARP, M. D., LONDON, OHIO.

President's Address before the Madison County Medical Society.

"Esse quam videri."

GENTLEMEN:—The subject upon which I have chosen to address you, is one which I have felt no little diffidence in approaching, for various reasons, among which I may mention some as follows:

1st. This subject has engaged the attention of many of the ablest thinkers and writers in the profession; it has been the subject of many

able addresses before our Medical Conventions and Assemblies; it has received the attention of medical instructors, from individual standpoints and as corporate bodies; it has been *discussed* and *cussed* in our medical journals until it almost savors of cant to refer to it.

2d. It has received recognition at one or more of the meetings of the American Medical Association, and at different times suggestions have emanated from this Association, and from other bodies of almost equally eminent prerogatives, and considerations, as to plans for elevating the standard of education as a result of the course prescribed and taught in our medical colleges, have been offered. How futile have been these suggestions and attempts, I hope to indicate to you further along in my address.

3d. With an evil so apparent, many have been the remedies proposed for its cure; and, in some few cases, the remedy has had a showing of practical application, but for various reasons that I shall mention, the evil still continues to afflict our calling without apparent abatement or modification.

With these as a few of the many reasons I might mention, I may well feel a diffidence in bringing the subject before you, but with a firm conviction that this subject demands the careful consideration of every physician in our republic who has the true interests of the profession at heart, and the Constitution of this Society providing that one of the objects of its organization shall be the advancement of the science and literature of medicine, I can offer no better reason for occupying a portion of your time to-day, than in asking your attention to what I consider of the very first importance in furthering the advancement and progress of the science of medicine, viz: A higher standard of education among our medical students and the graduates of our various medical colleges.

We are in the midst of the season when the numerous medical colleges are sowing broadcast the seed that they hope to bring them a plentiful return of students at their next term of lectures. There is hardly a mail but brings to almost every one of the 80,000 physicians of this broad land an announcement of the next course of lectures of some one or other medical college; and each announcement shows in the most glowing terms the many advantages to the medical student of availing himself of the rare opportunities offered for fitting himself for the grand calling he has chosen. These announcements are literally showered upon us, and it is expected that each one of these physicans has one or more students under his tutorship about whose medical education he is very anxious

and solicitous, and each one of the regular medical colleges thus indirectly assures him that it possesses superior advantages for preparing him for the pursuit of the high and noble calling that he has adopted.

It would doubtless be somewhat amusing to know the destiny of these numerous catalogues and announcements at the hands of the practitioners for whose edification they are so gratuitously distributed. The greater portion no doubt, with hardly a passing notice, find their way into the waste-paper basket to be fished out as needs be to wrap up a remedy, or cordial for the next patient seeking relief from some suffering or ill. Some doubtless glance over the formidable array of physicians composing the faculty, to mark the familiar name of some revered or honored Professor, long recognized as a distinguished teacher and perhaps writer in medicine; or to wonder at the comet-like tail of suffixes that attaches to doctors when they become associated with some medical college. It is simply confusing, laughable or astounding, according to the mood of the observer, to note with what profusion "A. M.'s and "Ph. D.'s, and so on, *ad infinitum*, attach to *Profs.* in some of our medical colleges, without regard to previous conditions or claims to scholastic attainments or collegiate training.

Some, doubtless, look over these announcements in a more or less critical manner, to learn if any of the medical schools have taken any new departure in their plan of instruction, and in their requirements for matriculation and graduation. In these particulars they all present the fairest promise possible, but, with three or four exceptions, there can be found in the announcements for the coming sessions of these institutions no material changes by which the standard of education among their graduates is to be raised. I do not have reference merely to the instruction and training in the science and art of medicine, but to the requirements for matriculation; the preliminary education that every one is supposed to have before he enters upon the study of medicine.

The time-honored maxim that policy should be subservient to principle, is apparently reversed in the efforts on the part of our medical colleges to swell their numbers of students. Their plan is to get the students at all hazards, and in their rivalry they sacrifice principle to policy; "hence the impossibility of exacting such a grade of preliminary requirements, or such a standard of medical education at graduation, as their own sense of propriety and responsibility would prompt them to adopt." This grows, largely, out of the plan upon which our medical schools are organized and operated as private and individual enterprises, the faculty depending

upon the fees derived from the students for the support of the institution, "This, it is, which has destroyed the independence of schools, and has compelled them to perpetuate a system of education which their private judgment condemns and their conscience reprobates." The ease with which charters for such institutions can be obtained, in many of our States, has caused to spring into existence medical colleges whenever a sufficient number of ambitious men, wishing to magnify their importance and to advertise their interests, and who have not enough native talent to otherwise attract attention, feel that they are called upon to labor for the elevation of medical science. They proceed to herald their superior advantages and qualifications for teaching medical students, in circulars and attractive announcements, which they scatter broadcast over the land; and to prove their unselfishness and disinterestedness, they offer to teach or treat every one gratuitously who will listen to or employ them. They offer every inducement for students to come up from the highways and by-ways, to be taught, almost without out money and without price. Their great desire and aim (?) is to elevate the standard of the medical profession, and at the same time they pay no attention to the preliminary qualifications of their students, but seem to think every man, "no matter how uncouth or ignorant he might be, is qualified to enter upon the study of medicine." In some of our medical colleges it would seem that one of the strongest recommendations for a Professorship is the amount of patronage a physician is able to control—the number of students he can bring into the school. The result is, we find many a young man abandoning the yard stick, or the work bench, or the plow, or whatever vocation he may be following, to engage in the study of medicine, and we find his preceptor is Professor Blank, in some medical college; and still this same Professor will, perhaps, be a leading spirit in our medical Conventions and Assemblies, and a clamorer for elevating the standard of the medical profession.

What avails it to attempt reform as long as this state of affairs exists! Personal self-aggrandizement and college combination have thwarted every attempt at reform, and until the general profession, individually and through the societies, take the matter in hand, any general advancement of the welfare of the profession will be utterly impossible. The selfish interests of medical colleges render it out of the question for us to expect from them any material advances toward reforming the evils that afflict and tend to degrade the high standing of our profession.

When Bellevue Hospital Medical College issued her announcements of

the session for 1880-81, the profession, or the honest and progressive men of the profession, hailed with admiration the departure as an advance in the right direction. The prestige of this institution, together with its large number of students in attendance upon its courses of lectures, and the long list annually graduated, led the profession at large to expect something permanent and practical in its efforts to secure the higher standard of professional requirement for its graduates; but imagine the disappointment, not to say chagrin and humiliation, that the honestly progressive men of our profession must have felt for the dignity and standing of its votaries, when, before the close of the session for which their announcement of reform was made had expired, the faculty issue a *special circular*, stating that their new departure is a failure; that they will return to their old system. The new system provided the requirements for graduation should consist in attendance on three terms of lectures of six months each, so graded that each term would comprise branches of study covering only a part of those of the entire course, and systematically progressive through the first, second and third years. This is what is termed the graded course, and it was made obligatory in their announcement. The failure, they very candidly acknowledged, consisted in the dropping off of numbers and the consequent reduction in the income from fees, which are so essential to the interests of the institution. In other words, the *great Bellevue* is not above the ways of her less illustrious sisters, whose measure of desire for the elevation of the standard of the medical profession is the measure of the purse and self-aggrandizement that accrue to the individual members of their faculty of instructors.

The effort to secure a higher grade of medical education is thwarted by the effort to secure the greatest number of students and send forth the greatest number of graduates—a standard measured by quantity instead of quality. While this is true, is it also true that the proportionate ratio of physicians in this country to the population, demands the large number of graduates ground out by the medical colleges every year? In the first place, we have, by far, too many medical colleges in this country. Including Homeopathic and Eclectic institutions, which have all the legal rights to confer the degree of M. D. that belong to the regular schools, there are about eighty medical schools, each striving to grind out the very largest possible grist of new doctors annually. There are annually produced in this way about four thousand new doctors, that are set loose upon an innocent and long-suffering people, and is it any wonder that every hamlet and cross-roads receives an accession of a *new doctor* every season.

There is no other country on the globe in which doctors are so numerous in proportion to the population, and so long as we have the portals of our medical colleges thrown wide open and every inducement held out to young men without regard to preliminary qualifications as to education and culture, to enter these institutions where they will be graduated and have all the legal rights to practice medicine and surgery, after attendance on two courses of lectures, varying in length of time from five to seven months, so long will this over-production continue, entailing upon the profession at large the responsibility of a weakened public confidence and a want of social respect for the low status of general and scientific culture that is charged upon our profession. "Every ignorant man," says Dr. Geo. E. Paget, "has an injurious influence on the estimation in which the entire body is held! His demerits have a tendency to lower us throughout the circle in which he is known. The want of confidence in him, and the want of respect for him, beget distrust and disrespect for the profession in general. A profession will be judged, not by a few shining lights, but by the condition of the body."

The proportion of physicians in this country to the population is about one to every six hundred, according to Pepper's tables, against an average of one to three thousand eight hundred in thirteen other countries in both hemispheres. "The evils resulting both directly and indirectly from the over-production of physicians alone, are of the most serious character, far-reaching in their influence, inimical, if not destructive, to the high social status of our profession as a body to which we are entitled by our constant devotion and liberal benefactions to public interests, while it is equally opposed to the welfare of the individuals of the body."

These evils are not inherent in the profession as a science, for it is the grandest and noblest of all callings that one may profess and follow. The cultured and advanced classes of every community know how closely identified are the influences of medical science, as represented by the progressive and honest men of our profession, with every moral, social and commercial interest and advancement. The physician occupies in the family a position of trust and confidence more responsible than that of any one else that is looked to as confidant, counsellor, or arbiter. In him are reposed confidences that would be more deadly in their effect to family ties and organization, if betrayed, than the bomb of dynamite is to material order and organization. Here is a demand for the very highest order of culture, because of the reflex effect that it may exert upon the whole social fabric.

Our charitable, benevolent and reformatory institutions, the indexes of any nation's moral and humanitarian undertakings, owe more to medical supervision and direction for their high order of success, than to any other factor. The protective influences of state medicine have almost stayed the ravages of pestilence and plague, thus largely adding to the stability and growth of the commercial interests of our large centres of population and turning our large cities into safe and healthful places of abode for their inhabitants.

A high order of public hygiene is a strong factor, conducing to a higher order of public morals. Our profession is a liberal one, our field of work a broad one, and one which offers the richest rewards for general culture and a high standard of professional attainments.

If it be true that over-production of doctors, like the over-production of the manufacturer, has a baneful and injurious effect upon the interests of the profession, having a tendency to lower the status of professional attainments, to create distrust in the laity, to cheapen the value of professional services in their estimation, and lessen their influence and status, socially, shall we not, like the manufacturers, shut down the mills for a while? We may not be able to regulate the power that runs the machinery of medical colleges, but the practitioners of our land can, by concerted action, control the supply of students, and thus almost directly determine the number and quality of their products.

Now, Gentlemen, while I have passed some strictures, in a general way, upon our medical colleges, I would not be understood as ranking them all in the same category, as regards the quality or efficiency of their course of instruction, and the advantages they offer for a thorough medical training. There are medical schools, both eastern and western, that offer in their system of instruction and their lengthened term of study, more thorough courses of lectures than others. We have some adopting the compulsory graded course, consisting of three terms of lectures, and making it obligatory on all graduates to take the full course. Then, some of those who adhere to the old system of requiring the candidate to have attended two terms of lectures, have lengthened their sessions to six and seven months, instead of five, as originally. Either of these systems, I think better than the two five months' courses, in which it is expected that one shall have given due attention to the didactic lectures, and acquired a good knowledge of the numerous special branches of ophthalmology, laryngoscopy, dermatology, etc. It is evident that the process of cramming must be very scientifically practiced, if a student in two short

terms of lectures can acquire anything more than a very superficial knowledge of these various subjects.

Now I believe it incumbent on every physician, who honestly believes that the dignity and high standing and the more closely connected interests and welfare of the medical profession are worth maintaining at the standard that characterizes them in other countries, and formerly held in this country before medical colleges became so numerous, to require of every young man who consults him with a view of entering upon the study of medicine, such a degree of education and culture as would fit him to enter the second year of the course of study as laid down in our colleges whose degree of A. B. is recognized in institutions of England and Scotland. This presupposes that he shall have a fair knowledge of the use of his mother tongue, and be well advanced in the higher mathematics, natural history and physics, and have made some progress in the Latin and Greek languages. I claim that unless a young man has had the discipline of the schools to this extent, at least, he lacks the mental discipline and habits of thoughtful application, that fit him for the most advantageous *study* of any profession, and the medical profession especially, not to say the qualifications that will enable him to take rank among the skillful and determined workers and observers, and able thinkers and writers, who are steadily and surely bringing about progress and advancement in our profession as a science and art.

Then, when the time arrives for the student to select the medical college in which he is to receive further medical training, his preceptor should see to it that it ranks among those which have taken steps to improve their course of instruction, so as to bring it up in the scale of professional requirements. When preceptors take this interest in the culture and education of their students, the supply of medical students will be of a higher order in cultured attainments and the second and third rate medical schools will be numbered with the obsolete, and the elevation of medical education will be arrived at.

When the faculties of our medical schools find that the advocates of a higher medical education are determined, and imperious in their demands for a fair degree of general culture, as a standard of admission, a lengthened term of study, compulsory clinical and practical laboratory instruction, and the establishment of post graduate courses of study, they will reform their systems in order to meet these demands, knowing that if they refuse they will don their professorial dignity in solitary seclusion and be compelled to deliver their lectures to the empty forms of the classrooms and amphitheater.

CASE OF SPONGE GRAFTING.—PARTIAL SUCCESS.

BY P. M. WHITE, M. D., TROY, OHIO.

J. V., aged 52, contracted an indurated chancre in 1861, which was followed by the ordinary sequelæ of an Hunterian sore. After passing through all the forms of secondary syphilis, which succeeded each other with rapidity, two ulcers made their appearance, in 1870, situated on the leg, two and one-half inches above the malleoli. Each was about the size of a silver dollar, with the edges hard, irregular and elevated, the bottoms filled with unhealthy granulations, and bathed in an extremely offensive sero-pus. A firm edema occupied the leg from knee to ankle, the skin having a mottled appearance. The bones were not implicated. This patient had been medicated with all known anti-syphilitic remedies, for about eight years, but they at no time seemed to have any beneficial influence upon the ulcers.

TREATMENT.—Upon strapping the leg with adhesive strips and removing the edema, we made small incisions in the edges of each ulcer, thereby thinning them in the course of a few days, but not closing the ulcers. We then applied skin grafts four times, but these also proved complete failures, the grafts either being washed off by the discharge or absorbed. On August 24th sponge grafts were inserted, each sponge being one-eighth inch in thickness, and cut to fit accurately into the ulcers. Carbolized lint was placed over the sponges, adhesive strips brought around the leg over all, and the whole being pressed firmly down, a light roller bandage completed the dressing.

September 1st the sponges were firmly adherent, the discharge greatly diminished, and no edema present. After waiting nearly three weeks for the absorption and disappearance of the sponges, we were disappointed in finding no diminution in their size. The edges of the ulcers seemed to be stimulated under the irritation of this peculiar graft, becoming thin, regular and of a healthy appearance. Upon elevating the edge of the sponge, beautiful granulations were observed springing into the meshes of the central portion, and bleeding was readily produced upon slight irritation. The granulation disappeared from the circumference of the ulcers first, and a strong layer of cicatricial tissue was substituted in that portion of the foul, angry looking sore. Unfortunately the case disappeared before a complete cure was effected by this rather peculiar method of treatment.

Taking the desperate physical condition of the patient into considera-

tion, together with the chronicity of the ulcers, we were more than satisfied with the practical application of the sponge graft and its results. Regarding the theory of its action, very little has been said as yet. Whether the sponge acts as an antiseptic, in preventing the deposition of organic material from without, or whether the sponge has some peculiar property inherent in itself in generating skin granulations, remains to be demonstrated. Or, it may act merely mechanically, stimulating granulation by its presence, and serving, by its meshes, as a support for the granulations that develop into its substance, until they finally displace it by its absorption.

SELECTIONS.

OBSTETRICS.

THE APPLICATION OF PRESSURE IN DISEASES OF THE UTERUS, OVARIES AND PERI-UTERINE STRUCTURES.—(By V. H. Taliaferro, M. D., Atlanta, Ga., Professor of Obstetrics and Diseases of Women and Children in the Atlanta Medical College.) At the annual meeting of the Medical Association of Georgia, held in Atlanta in April, 1878, I submitted a paper upon "The Application of Pressure in Diseases of the Uterus." This subject was designed to embrace those disorders of the peri-uterine structures so frequently, and I might say constantly, co-existing with diseases of the uterus. It was shown in the detail of cases that the congestive, hypertrophic and hyperplastic affections of that organ were curable by the *pressure of the tampon*. It was also shown that the inflammatory deposits and adhesions so often co-existing and seriously complicating those disorders, and which hitherto had been regarded as incurable (save in exceptional cases by time), were equally amenable to the same simple method of treatment. Of the four cases referred to, illustrative of this new method of treatment, two had retroflexion of the uterus with *deposits of lymph and adhesions*. The application of pressure by the tampon in these cases was made not to remedy the displacements (for this was impossible in consequence of the fixation by adhesions), but to relieve the congestion and disordered local nutrition, and to destroy by disintegration and absorption the deposits of lymph and to make admissible the use of the pessary if needed. This was successfully accomplished in two and

four months, and the displacements subsequently rectified by the Albert Smith pessary. The adhesions yielded in these cases in less than the usual time. I rarely promise a cure under four or six months; and in old cases where the deposits are extensive it will often take a very much longer time of continuous and persistent treatment. I have yet to encounter a single case of this nature that failed of steady and continuous improvement from the beginning of treatment, and of final cure.

Usually in these cases of inflammatory deposit there is a subacute or chronic pelvic peritonitis, with a marked tendency to recurrent acute attacks. In such conditions the life of the patient is threatened with each recurrent attack, either by extension of the serous inflammation, or cellular abscess, or both, as is most usually the case. This tendency to recurrence is promptly arrested by the tamponade, and the patient in the majority of cases speedily relieved of her necessary confinement to room and bed.

The treatment of pelvic adhesions, by forcible elongation and rupture, advocated by Dr. Van DeWarker, of Syracuse, N. Y., at the late meeting of the American Gynecological Society, was very properly condemned in the discussion which followed the reading of the paper. The only safety of the patient from hazardous consequences in these attempts at forcible rupture, is the facility with which the anterior rectal wall yields to the force applied, permitting the elevation *en masse* of rectum, uterus and deposits. The only safe and rational methods of treatment in these pelvic deposits and adhesions when chronic, are by the *hot water vaginal douche* of Emmet, and *pressure by the tampon*, as taught by myself. As to the comparative merits of these two methods there can be no question. True, when the inflammation is *acute* the hot water is preferable and the tampon contraindicated, but when the inflammation is chronic, and organized lymph has *fixed* the pelvic organs in an adherent mass, then *the tampon* is the remedy *par excellence*. Indeed it is the only remedy by which we can as yet hope to free the organs from their imprisoned adhesions. If the tampon was applicable alone to this class of cases it would be a priceless addition to our therapeutic resources, but as we shall see it covers a large field in uterine pathology—a pathology in which congestion and its sequences stand pre-eminent.

The therapeutic action of pressure by the tampon may be thus classified: 1st. It diminishes blood supply and nutrition. 2d. It increases absorption. 3d. It destroys hyperplastic tissue by retrograde metamorphosis. 4th. It diminishes nerve activity. 5th. It rectifies displace-

ments. In comparison with other methods of treatment I claim for pressure by the tampon: 1st. More immediate and rapid results. 2d. Patients are not confined to bed, but on the contrary, the pressure affords them such relief as enables them to walk about in pursuit of their ordinary employment and pleasures, while by the ordinary measures of caustic, sponge tents, etc., a more or less prolonged rest and confinement to bed is necessary. 3d. *The suspension of sexual connection*, a therapeutic auxiliary of importance and one usually beyond control by the ordinary methods of treatment. 4th. Security from the inflammatory accidents incident to caustics, curette and tents. 5th. Softening and dilatation of the indurated tissues, while caustics and curette toughen and contract them. 6th. The integrity and vitality of the parts are maintained, while by caustics and curette there is a sacrifice of the normal structure, often damaging and irreparable.

In all uterine congestions we have excessive blood supply and nutrition. Pressure diminishes these, and hence its application to a large class of uterine disorders. In subinvolution, in displacements, in endometritis, in cervical rupture, it is the accompanying congestion and increased nerve activity which give rise to the pain, the distant sympathies and nervous anguish. Nothing so certainly illustrates this fact as the rapid disappearance of these symptoms by the application of pressure. In the supernutrition of old congestions so often found in subinvolution of the uterus, the common result is proliferation of connective tissues, as we have it in areolar hyperplasia, or the chronic metritis of older writers. This condition has been for all time the opprobrium of gyneologists. It is here that the entire armamenta of caustics, from the most powerful to the mildest, have done their best, and left only wounds and scars and irreparable damage. It is here that the tamponade is most happy in its results—promptly lessening the blood supply and restoring the nutrition of the tissues; destroying by disintegration and absorption the adventitious structures, and restoring the enlarged and indurated organ to its normal size and condition.

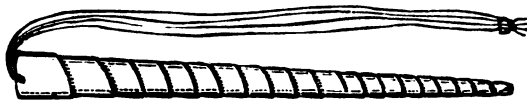


Fig. 1.

In very old cases of this kind where the tissues have become thoroughly hardened, and the progress of cure is found to be slow, we often extend the pressure to the uterine cavity by means of the cloth tent (see Fig. 1) to the cavity of the uterus in conjunction with the vaginal

I.—5.—4.

tamponade. Upon each renewal of the tampon an additional tent may be used, until as many as five or six are introduced at one time. In this way we get thorough dilatation and softening of the uterine structures without confinement to bed and without discomfort to the patient. Of course, where tents of any kind are used we must be sure that no contra-indication exists in the way of perimetritis or peri-uterine deposits, or great tenderness of the uterus. These must all be thoroughly removed before tents are admissible.

In cervical rupture, complicated as it so invariably is with congestion and excessive nerve activity, the pressure of the tamponade affords us a simple and pleasant remedy for the rapid restoration of the organ to a healthy condition preparatory to operation. In a case of extensive bilateral rupture of the cervix recently operated on at my private infirmary, the cervix was thoroughly everted and covered with angry granular erosions. In this case, as in others, I touched the eroded surface thoroughly every few days with sulphate of copper. Usually the erosions disappear by the pressure with the disappearance of the congestion, but when they are obstinate the blue stone is my favorite remedy. Where the diseased condition of the mucous membrane extends to the cavity, and that structure breaks down in fungous degeneration, the blue stone is an effective and valuable adjunct to the tampon in the restoration of the mucous membrane to its normal healthy state. In using it, first dilate the cervical canal with the cloth tent as directed; wash out the uterus with warm water, and then with forceps carry a suitable piece of solid blue stone into the cavity and apply it to every part. One or two applications will usually be sufficient. In using the remedy in this way some years ago upon a patient preparatory for operation for extensive bilateral cervical rupture, the piece of blue stone of some size dropped from the forceps in the cavity of the uterus, and I was unable to clasp it again in the instrument. The blue stone is a painful remedy and I was very fearful as to the immediate result. The patient lived about two and a half miles from my office, and after applying a light tamponade, the first pledgets saturated with glycerine, I sent her home in her carriage, with instructions to take to her bed upon arrival and send for me if she had any considerable pain. At my visit the next day I found to my surprise that she had gotten along with tolerable comfort. Upon removal of the dressing I found it thoroughly colored with the blue stone, and with no unpleasant effects upon the vagina. From this simple application the fungous granulations and menorrhagia which had been so troublesome and a complication in this case, disappeared to return no more.

I am convinced that in a very large proportion of cases of the so-called *endometritis*, granular erosions and fungous degeneration of the endometrium, congestion is the prime pathological factor. The terminal venules and arterioles of the uterine blood-vessels form a dense and delicate network upon the uterine mucosa, and hence in old congestions of the uterus the mucous membrane so often breaks down in fungous degeneration with its distressing and troublesome sequelæ.

How often, indeed, do we find granular erosion of the os extending into the cervical canal without involvement of the Nabothian glands. The thick tenacious mucus which plugs the os in cervical endometritis is pathognomonic of glandular inflammation. The cervical erosion of the os uteri and fungous degeneration of the endometrium often exist independent of inflammation. The softening and breaking down of the mucous membrane is the result simply of long continued congestion and malnutrition. Acting upon this pathology as well as from the bad results following them, I have well-nigh ceased the use of caustics and the curette.

In threatened abortions, whether occurring from displacements, congestions, cervical rupture, or the so-called irritable uterus, the tampon is a valuable resource. I am quite sure I have been able to carry a number of cases to term by this means that must otherwise have miscarried. Some of these cases were of the habitual variety—the most intractable, perhaps, of all others.

In several cases of inveterate nausea and vomiting, with great exhaustion, and confinement to bed for weeks, the relief afforded by the tamponade was almost immediate, the patients being soon out of bed with good appetites, eating well and retaining the food.

The irritable bladder which so frequently complicates the uterine trouble, is often the first symptom to disappear upon the application of pressure. Where the uterus is adherent to the rectum, or the cervix is drawn back by shortening of the utero-sacral ligaments with the posterior wall of the bladder necessarily dragged backward, an irritable bladder, with frequent and painful urination, is the common result. In these cases I know of no treatment comparable to the pressure.

In chronic inflammation, congestion and enlargement of the ovaries, the pressure acts as promptly and efficiently as in congestion of the uterus. In a number of cases of this nature I have been agreeably disappointed by the happy results.

I have used the tampon in a number of cases of fibroid tumors of the uterus, and while I cannot in any case report cure, I can in every case

report decided improvement, both in the general health and the local affection. Usually the menorrhagia and the metrorrhagia have been promptly controlled and the menstrual interval made complete. When the menstrual hemorrhage is considerable, I am in the habit of keeping up the tampon through the entire menstrual period. The tamponade when made with glycerine and iodoform, directly to be described, quite sufficiently controls the hemorrhage, and makes a thoroughly antiseptic dressing. If, as occurs in some very obstinate cases, the hemorrhage is not sufficiently lessened to make it approximate in quantity the normal flow, then the glycerine may be left off and iodoform and tannin used. The tampon in these cases should be renewed daily, but I have several times, from providential causes, left them for five or six days, without detriment to the patient, and when removed found to be free from odor. While pressure is being made by the tampon, if the patient be required to encase herself in a long and tightly-fitting corset, and at the same time slowly but thoroughly saturate her system with ergot, the worst of these cases will steadily and surely improve.

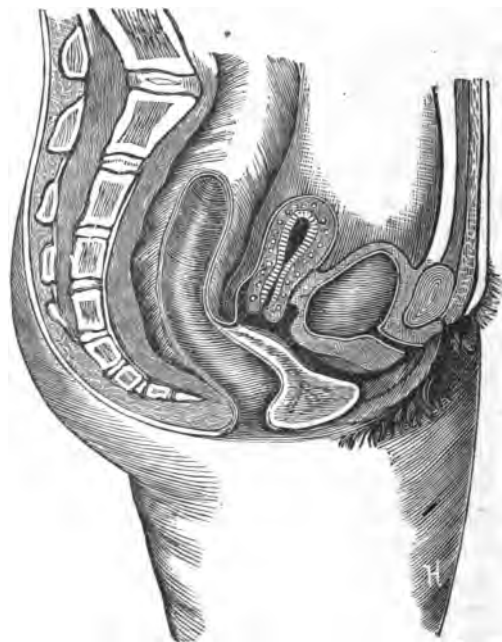


Fig. 2.—Showing normal condition of the pelvic organs, to be able the better to appreciate the principles here taught.

Original Method of Applying the Tampon.—My original method of using the tampon for the application of pressure in diseases of the uterine organs, appears in a paper presented to the Medical Association of Georgia, convened in Atlanta in April, 1878, and is thus described: "In applying the packing, it should always be borne in mind that the vaginal canal *must be distended and elongated* to its utmost capacity; and the uterus must occupy its utmost degree of elevation in the pelvis. These can be obtained only *in the knee-chest position* so accurately described by Dr. Sims.

"The material for the tampon should be of *sheep's wool*. Its elasticity and porosity especially fit it for this purpose. It should be clean and carded into bats and properly disinfected with carbolic acid. The essential pre-requisites, then, for the packing are: *the position of the woman*, Sims' speculum, dressing forceps and sheep's wool.

"Before a good direct light, across the bed, upon a good hard mattress, or better upon a table, the patient is placed upon her *knees and chest* with the knees *directly* under the hips and a little separated. The thighs

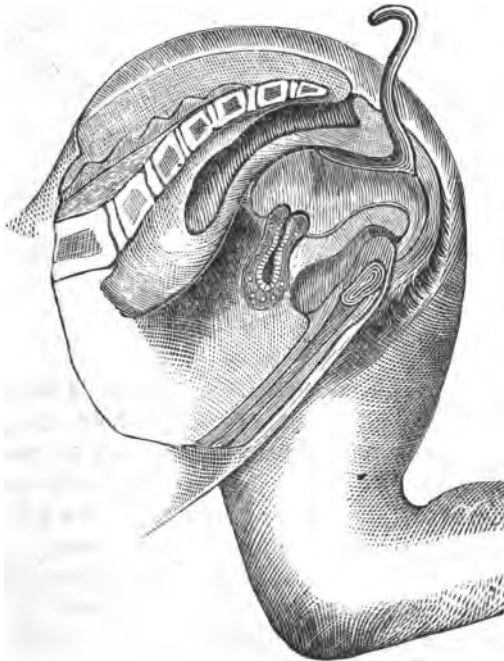


Figure 3.

perpendicular and at right angles with the table. 'She must not arch the spine upward, for this brings into forcible action the abdominal muscles, which should be perfectly relaxed, with the spine curved downward as we see it in sway-backed animals. With these precautions fully impressed upon her, she is to breathe easily and relax the muscles of the abdomen.' (Sims.) Dress-strings and corsets should be removed and loosened completely. Many women, especially short ones, are unable to bring the chest flat upon the table, but they can 'bend the body forward until the head is brought down to the plane of the table, where it must rest in the two hands, its weight supported on the left parietal bone, while the *elbows are thrown widely out from the sides.*' (Sims.)* The *outstretched elbows* bring the chest as nearly as possible always upon the table. These details may appear tediously careful, but without an attentive observance of them the tampon will fail in its object. The carded wool bats should be broken into pledgets, or separate pieces, the patient in position as described, the perineum elevated with a short and broad blade Sim's Speculum, and we are ready for the packing. The first one or two pieces of

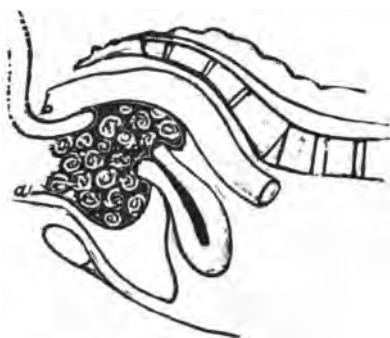


Figure 4.

the tampon to go immediately over the cervix should be *cotton*, well filled with the best quality of glycerine. The cotton holds the glycerine better than the wool. These little pieces should contain as much glycerine as they can be made to hold, by placing the cotton in the palm of the hand and rubbing in the glycerine little by little until it is a pulpy mass. These may be placed, with the dressing forceps, immediately upon the cervix, or one behind it and the other in front. The pledgets of wool are then applied dry, each one being successively rolled upon itself rather tightly in order to give the requisite firmness and solidity to the packing. The

*Italics mine.

vault of the vagina is first well filled and the packing proceeded with *carefully*, the pledgets rolled upon themselves being placed here and there and packed with dressing forceps; all parts of the vagina being packed as equally firm as possible, and yet not too solid at any point for comfort. The vaginal canal is thus filled down to the muscular floor of the pelvis, but not below it. If the vaginal outlet is distended it will give discomfort, and a portion of the tampon may be lost. The vaginal orifice should close over the filling."

This method of packing the vagina is illustrated in Fig. 4.

I have long since discarded the sheep's wool for cotton, which I originally used. I was induced to do this because of the superior convenience of the cotton, and because it can be made more compact, and hence a greater degree of pressure obtained. Instead of extending the tampon

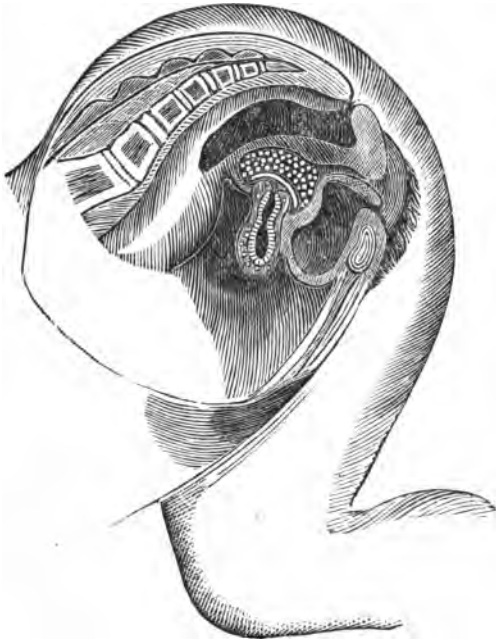


Figure 5.

from the vault of the vagina to its floor, I now rarely extend it further than the upper third of the vagina, and often not more than the upper fourth. In case an extra degree of pressure is desired, the upper half or still more rarely the upper two-thirds of the vagina is packed. In the

large majority of cases of congestion, displacements and adhesions, the tampon is made to occupy only the upper fourth of the vagina. (See Fig. 5.) If the tenderness of the organs admits it, this partial tampon should be *very firm*. If there is considerable tenderness the dressing should be very light, and the pressure gradually increased as the tenderness subsides, until the packing is made as firm and compact as it can be made. When *pressure* is desired, a loose packing is not sufficient, and the so-called columns of Bozeman are worthless. This column is simply a loose, flat tampon extending from the posterior cul-de-sac to the ostium vaginae. It can give neither *support* nor *pressure* to the uterine organs. Its value consists mainly in separating and possibly softening the vaginal walls, for which it was used by its author until he read my paper in the spring of 1878.

The tampon applied only to the upper third of the vagina does not interfere with the bladder or rectum by its pressure upon those organs. The lower portion of the vagina closes in the tampon which occupies its vault. The tampon is thus securely held in place and rests upon the elastic column formed by the approximated vaginal walls.

The advantages of the tampon thus applied are: 1st. It does not reach the urethra nor make uncomfortable pressure upon the bladder and rectum. 2d. It answers all the purposes of pressure of the more extensive tampon. 3d. It does not interrupt the physiological mobility of the uterus. 4th. It keeps in place more securely than the more extensive tampon.

In witnessing the application of the tampon by my medical friends, some of whom are familiar with uterine manipulations, I have been astonished at the *awkward* manner in which the operation is made. Almost invariably the tampon is applied lightly in the vault of the vagina, and very tightly as the vaginal outlet is approximated. Such a tampon utterly fails in its objects, and is worn by the patient with great discomfort. The packing should always be tight and firm in the vaginal vault, and if this is properly done no advantage is gained by filling the lower part of the vagina.

The size of the uterus should be closely watched during treatment by the tampon. If it is continued after the uterus has been reduced to its normal size, *atrophy* of that organ, with deficient menstruation, will result. I have had several cases of this kind, where the uterus in the beginning was abnormally large, and have been obliged to restore the size of the organ, with its impaired function, by the use of the stem pessary. How

long should the tampon remain in place? For the first few weeks of treatment the renewal should be made every two days, and subsequently every three days. I have often left the tampon for six or seven days, and several times, from providential causes, have permitted it to remain for twelve days, and once for four weeks, and in every instance found it upon removal perfectly free from odor. In these cases iodoform was a constituent of the tamponade. Where the patient is accustomed to the tampon its long retention does not give discomfort if it has been properly applied and disinfected. As an antiseptic and disinfectant I know of nothing equal to iodoform. I have never removed a foul tamponade when iodoform was one of the ingredients used. The first pledget of cotton, which should be large enough to spread over the cervix and in part the vaginal roof, (see Fig. 5) should be thoroughly saturated with the *best glycerine* and then spread with an ointment made of iodoform, 3j; balsam Peru, ʒij; vaseline cerate, ʒj; the balsam of Peru thoroughly deodorizes the iodoform and gives us a perfect disinfectant. Its disinfect-

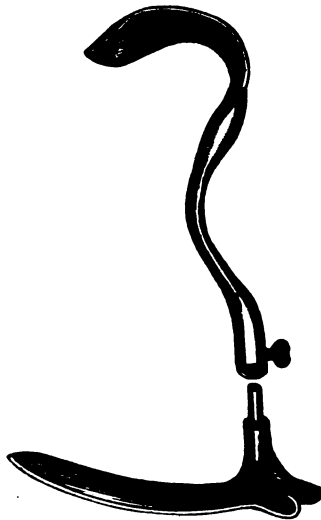


Figure 6.

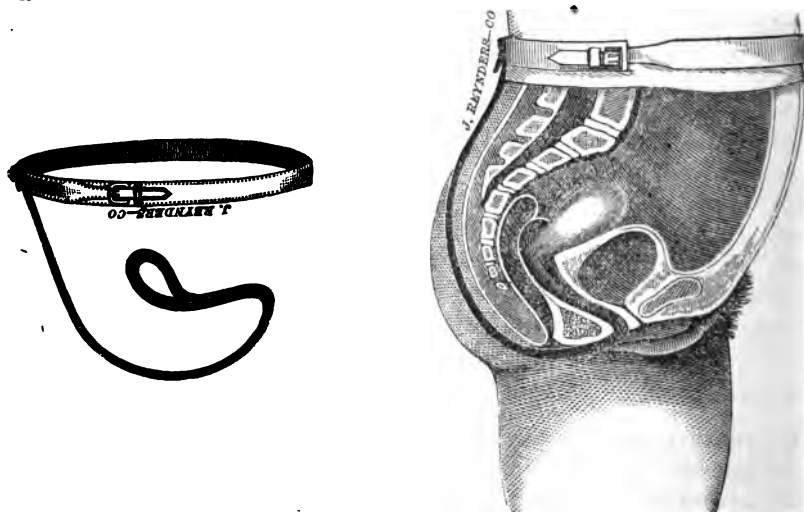
ant, sedative and alterative powers render it peculiarly valuable as a uterine remedy. It is quite fusible and quickly absorbed into the surrounding structures, upon which it exerts its stimulant and alterative powers. In inflammatory deposits and adhesions I regard it as especially serviceable as an adjunct to the tampon. It was recommended as a local remedy

I.—5.—5.

in my paper upon "The Application of Pressure in Diseases of the Uterus," published in 1878, and I do not know of its having been used in uterine therapeutics prior to this date. In some patients when the system become saturated with the remedy, it causes an unpleasant nervousness, and occasionally I have had to suspend it or use it in reduced quantities. Tannin is often serviceable, used in conjunction with the glycerine and iodoform. Where the uterine organs and periuterine structures are excessively tender a poultice made of flax seed meal, glycerine, tannin and iodoform, gives great comfort and rapidly improves the condition of the parts. The poultice is easily applied upon pledgets of cotton over the entire vaginal roof and held securely in place with the tampon, which occupies the upper vagina.

The perineal elevator seen in place in Fig. 3 is better represented in Fig. 6. The blade is flat and thin, like that of Nott's speculum, and flanged at the proximal end to separate and hold apart the nates. The handle terminates in a curve to fit the hand, and is light and more convenient for tamponing than an ordinary Sims' speculum.

NEW PESSARY.—Dr. S. J. Donaldson, whose *Contributions to Gynecology* is noticed elsewhere, has presented the profession with a new pessary



for retroversion and retroflexion. It is a modification of the Cutter pessary. It consists of a copper wire loop, bent so as to conform to the

vaginal curves and perineal body, covered with smooth, soft rubber, which is continuous with a light tube of the same material attached to a band surrounding the body.

The advantages claimed for it are: 1. It is readily moulded to any desired shape, and is therefore a retroversion, retroflexion, anteversion, or stem and ring pessary.

2. It fits the perineal angle accurately, and being soft, smooth and pliable at this part, does not abrade the tissues, nor inconvenience the patient when sitting.

3. It is easily managed, and can be inserted and removed at pleasure by the patient.

In the construction of his pessary, Dr. Donaldson has made a special study of the anatomy of the female pelvis and pelvic organs, and has conformed his pessary accordingly.

The cuts show the retroflexion pessary and its application.

SURGERY.

THE TREATMENT OF CARIES IN THE CERVICAL VERTEBRÆ.—In the *New York Medical Journal* for October, Dr. Roberts discusses the now prevalent treatment of Pott's disease according to the Sayre method. He points out that the percentage of recoveries is greater in cases where the disease is above the level of the axillæ, and is therefore treated by the jury-mast, than in caries of the lower dorsal and lumbar vertebræ where the plaster jacket alone is used. He further claims that the method of Sayre is essentially different in its action in the two cases. Below the axillæ it is, as described by its author, an extension of the diseased structures, with nearly complete fixation, the aim being of course ankylosis. When, however, the jury-mast is used, there is fixation of the healthy vertebræ only, and the elasticity of the metal rod keeps the cervical vertebræ in a condition of elastic extension, so that the diseased surfaces are kept from irritating each other, but are allowed to move with the effort of the patient. This he believes to be the true theory of treatment, and the facility with which it is applied in case of cervical disease accounts for the better results in such cases. It is in like manner, however, a desideratum for all cases of Pott's disease. The fixation by means of a plaster jacket is not desirable, but because it seems to be the only way to get a good foundation for the jury-mast, must at present be

tolerated. Indeed it can better be afforded over vertebræ which are healthy than over those which are diseased. The elastic tension desired for the cervical vertebræ can be still further secured by substituting elastic bands for the unyielding ones used by Sayre. The writer claims that cases so treated recover quicker and *without anchylosis*, so that the movements of the head and neck are as free as ever. The *point d'appui* of the supporting apparatus should not be (as according to Sayre) from one point at the back of the jacket, but the ends of the support should be carried forward around the sides of the chest so as to bring the bearing more nearly in line with the centre of gravity. Finally, the jury-mast being altogether a conspicuous and awkward affair should be substituted by a mento-occipital cushion carried on springs from a frame inserted in plaster, so as to secure the same elastic tension, without any curved rod passing over the head.

Since this article was written Dr. Roberts has read a paper before one of the local societies in New York, in which he describes the successful application of this theory to the treatment of dorsal caries. A jacket is applied, and then divided horizontally over the seat of the disease, the upper and lower segments of the spinal column being kept apart by elastic tension secured by strong spiral springs having their ends embedded in the plaster. The lower portion of the jacket takes support from the crests of the ilia, and the upper from the occiput or the thorax, according to circumstances.—*Boston Med. and Surg. Jour.*

FAT EMBOLISM AFTER FRACTURE.—From a careful study of the cases, and a review of the literature of fat embolism, Dr. A. Minich (*Lo Sperimentale*) has been led to consider that the condition is much more frequent than has been supposed. He concludes as follows: 1. In every fracture there is more or less fat embolism, though in children it may be wanting or very insignificant, on account of the small amount of fat contained in their bones. 2. Very seldom is fat embolism by itself the cause of death or alarming symptoms. 3. Non-infectious fat gives rise neither to pyemia nor inflammation. 4. Death depends principally upon the suspension of function of the nervous centres, which is reduced by ischemia. 5. The presence of pure or emulsified fat in the urine occurs chiefly in severe and dangerous cases of embolism. It may often appear without grave symptoms. 6. The occurrence of death from fat embolism after fracture must be borne in mind. 7. The therapy is merely, thus far, symptomatic and of very little effect in preventing a fatal result.—*Amer. Med. Digest.*

MEDICINE.

CHECKING PULMONARY HEMORRHAGE WITH SHAWL-STRAPS.—Dr. H. H. Curtis, of New York, has written an article in the *Medical Record*, containing an account of hemorrhages quickly controlled by the above method of treatment. Dr. C. had a pair of ordinary shawl-straps punched with holes a quarter of an inch apart, and also braided three strands of rubber-tubing so as to make two cords, two feet long. To use he laid a folded napkin over each femoral vein, just below the fold of the groin, and adjusted the straps about the thighs as high up as possible, so that the buckles would be over the napkins. The straps were tightened then enough to stop the venous return without interfering with the arterial flow. Then the arms near the shoulders were bound by the tubing. The hemorrhage, in the case reported, was checked almost immediately. In about five minutes the straps and tubing were loosened, when the patient complained of a great shock to "the sore place," and the bleeding recommenced. The same procedure checked it as before. In about five minutes the straps were loosened, a hole at a time, when no hemorrhage recurred. No less than fourteen hemorrhages were checked by this method. The respiration was greatly relieved by keeping an arm and the opposite leg strapped. As soon as a limb became cyanotic the strap was changed to the opposite side.

ACID DRINKS.—Dr. J. H. Hanaford writes as follows: It is an established principle that cold and hot weather demand clothing and food of a different character, adapted to the varying circumstances. In cold climates and in cold weather the appetite demands, and the comfort of the body justifies, an increased use of carbonaceous food, that the animal heat may be sustained at the vital point of 98° Fahr. The natural appetite, which is a good guide—demands a change in diet as the spring opens; the disuse of the concentrated foods, the oils, sweets, etc., and the adoption of the succulent products, with those especially containing the sub acids. And, in accordance with this fact our ever watchful and kind Provider has given us just the needed medicine foods on the return of warm weather, the berries which are more acid than those appearing later in the season, as all may observe. They are demanded as one means of thinning and purifying the blood, or ridding it of the carbon accumulated during the winter. These acids stimulate the liver to increased activity, removing the waste matter, including that especially

from the brain and nerves, which we call "bile," which—in accordance with the same wise and beneficent plan—acts as nature's cathartic, stimulating the bowels, etc. to normal action. It is also true that custom, based on a temporary "craving," demands the use of greens and the like, the prominent feature of which is the acids used—the cooling element. It is unfortunate that in the use of acids we do not select the best, as the natural ones, instead of vinegar, produced by the last or putrefactive stage of the fermentive process, and that in the use of pickles we do not use ripe products, as the beet and the like, instead of the acrid and worthless one-tenth grown cucumber. If we need the acids—as we do—it is far safer to employ them as drinks, as the tartaric acid, the citric and malic, thus avoiding unripe and semi-poisonous fruits. Of the spring medicines I know of none equal to the Acid Phosphate made under the supervision of Prof. Horsford, late Rumford Professor at Harvard. It is not merely a medicine but a food as well, containing, in addition, a pleasant acid—like the "Bread Preparation"—some of the important constituents of the human body. It may be used as a substitute for lemons in drinks, or as a medicine in bilious affections, but is still more efficacious in its action on the brain and nerves, reaching cases of "nervous prostration," so prevalent. It is believed that it may well displace the cathartics, the fashionable "bitters"—often decidedly intoxicating—as well as the "tonics" and stimulants which do so much harm by undue forcing of the system, to be succeeded by a reaction, instead of nourishing the body.—*Med. Jour.*

ON THE MANAGEMENT OF PRURITUS IN ECZEMA OF THE ANUS OR GENITALS.—(L. Duncan Bulkley, M. D., in the *Medical Record*.)

The itching in these cases is often most intense, and the patient will plead that if he can only have something to stop the itching the disease will get well. I have repeatedly had cases where all sorts and all kinds of measures had been previously prescribed with a view of arresting the itching, but in vain, whereas the case yielded speedily when complete treatment was instituted, including only very mild local measures. Quite recently a physician brought a patient in consultation, not in regard to any general management of the case, but only to have my opinion in regard to the probable utility of applying the actual or galvanic cautery to the parts to arrest the itching. I have had cases which had previously been given stronger and stronger local applications, with a view of checking the itching, after the failure of recognized neurotic local remedies, until

the parts had been brought to a terrible state of inflammation from such applications as strong citrine ointment and the like. Now, while these may succeed in some cases in which, perhaps, a transient digestive disturbance was the starting point of the eczema, I am confident that in the main all such attempts in the way of a local treatment of eczema in these parts is false in theory and injurious in practice.

The measures which I am about to detail may be simple, but will in most, if not all cases, be sufficient as local treatment, provided that all else has been carefully attended to, as implied in the preceding brief mention of dietetic, hygienic and internal medication.

I place great reliance upon hot water as a means of relieving the congestion of the parts and the consequent itching. But the water should be indeed hot, and not warm—so hot that the hand can not be thrust wholly into it—and it should be used in exactly the manner now to be described. I speak thus positively because I occasionally hear it asserted by patients that it is not of service; and on inquiring I find that the exact rules have not been followed, or that it has been used for a longer time, or oftener than prescribed. The patient should sit on the edge of a chair and have a basin with the very hot water and a soft handkerchief in it. This latter is then picked up and held in a mass to the anus or genital parts as hot as can be borne, say for a minute, and then dipped in the water again, and the process repeated three times, the whole not lasting more than two or three minutes; too long bathing, or too frequent sopping of the part, or rubbing with the cloth, etc., makes matters worse.

Before the hot water is gotten ready, I have the ointment which is to be employed spread thickly on the wooly side of surgeon's lint, cut of a size to cover the affected parts, only, and laid close by ready for immediate use. After the parts have been soaked with the hot water for the prescribed time, they are rapidly dried by using a large, soft linen napkin upon them, with absolutely no friction, and the already spread cloths are immediately applied, the object being to at once exclude the air entirely. Ordinarily it is necessary to use the hot water only a single time in the twenty-four hours, namely, after undressing, and when ready to get into bed. It must be premised that the patient is to so manage as not to indulge in the usual scratchings before undergoing these manipulations. If this desire is given way to beforehand, the treatment will not always control it at once; but if the patient can avoid even touching the parts, except as described, he or she will commonly be quite able to go to sleep immediately. I have repeatedly had those thus afflicted say that the first

night of treatment was the first real rest they had had for months or years.

If the case is very severe, and if there are spells of recurrent itching, the hot water may be repeated occasionally; but it is commonly sufficient simply to renew the ointment one or more times in the day, especially in the morning on rising, without the repetition of the hot water, which latter, I think, sometimes acts prejudicially in softening the parts if used more frequently. It should be added that the ointment should always be spread on lint and never be rubbed on the part; also, that in applying the lint it should be kept in close apposition to the diseased surface, and that by means calculated to heat the parts as little as possible; and finally, that in renewing the dressing the fresh cloth should be spread and ready near by before removing the previous one, that the access of air to the parts may be prevented by changing the covering as quickly as possible.

The ointments employed must vary somewhat with the case, and no single one could be mentioned which would be invariably of service. That which I most commonly prescribe is made as follows:

R Unguent. picis..... ʒ j;
 Zinci oxidi..... ʒ ij;
 Unguent. aquæ rosæ (U. S. P.).. ʒ iij. M.

This should be of a consistence which spreads and remains soft, which may be easily regulated by varying the proportion of the spermaceti in the rose ointment or cold cream. I may add that I never employ the recent products of petroleum, cosmoline and vaseline, as a basis for these ointments where protection of the surface and exclusion of air is desired, as they have not body enough to remain as a thick coating upon the part, but rapidly soak in and leave the parts dry and exposed.

PRURITUS ANI.—Dr. H. K. Steele (*Cin. Clinic*) recommends the following as almost a specific for pruritus vulvae or ani: R. Quiniæ sulph. ʒ j; adipis, q. s. Ft. ung. S. Sig.—Apply freely, as needed.

PRURITUS ANI.—A writer in the *Cin. Lancet and Clinic* speaks very highly of balsam of Peru. It seems to palliate rather than cure.

FOR FROSTED EXTREMITIES.—It frequently happens that, after mild degrees of frozen extremities, for years, disagreeable pains and a very annoying pricking in the parts make their appearance from time to time,

especially during the colder seasons, and on sudden changes of the weather.

Under such circumstances, Lapatin of Tiflis, recommends the application to the affected parts, once or twice daily, of a mixture of equal parts of dilute nitric acid and aqua menthæ. After a few such applications the skin assumes a brown color, becomes dry and a superficial scab forms, which, when thrown off, leaves a healthy skin. Within one and a half or two weeks the disagreeable sensations disappear forever.

ANTISEPTICS IN PHTHISIS.—Dr. William Porter, Physician to Throat and Lung Department, St. Luke's Hospital, St. Louis, thus summarizes: Proven, it seems to me, are these two propositions:

1st. Phthisis is a specific disease from a specific cause.

2d. Phthisis may be produced by absorption of tuberculous matter in contact with the mucous membrane of the air passages or intestinal tract.

There is also evidence that the energy of this tuberculous matter is due to germ development and progression.

Hence the value of antiseptic influence in the treatment of phthisis, not only in the later stages during pus production and absorption, but also in the earlier process of infection.

One great demand is for that, which, by local and internal use, may meet and destroy the septic agencies of disease. Such a remedy must be effective, unirritating and non-poisonous, susceptible of ready dilution and easy absorption, and withal inoffensive in odor and taste.

Carbolic acid and iodoform do not fully meet these requirements, and less harmful yet no less potent means of antagonizing contagion and putrefication are finding favor.

The compound known as Listerine has for nearly two years served me better than any other remedy of its class, and, in the treatment of phthisis, has almost supplanted in my practice all other antiseptics.

In treatment of diseases of the upper air passages it is pleasant and does not irritate; in the fermentative dyspepsia so often accompanying phthisis it is safe and efficient.

It is the most powerful non-tonic antiseptic I have yet found.

REVIEWS AND BOOK NOTICES.

Prices are always inserted when furnished by the publisher, or when obtainable from the bookseller.

The International Encyclopedia of Surgery, a Systematic Treatise on the Theory and Practice of Surgery by various Authors and various Nations. Edited by John Ashhurst, Jr., M. D. Illustrated with Chromo-Lithographs and Wood Cuts. In six volumes. Vol. II. New York: William Wood & Co., 1882.

This volume opens with articles on local affections, such as Wounds, Burns, Abscesses and Gangrene. Then follow elaborate articles upon the various venereal diseases—gonorrhœa, the simple venereal ulcer or chancre, syphilis, vegetations, etc. In the latter part of the volume is begun the consideration of injuries and diseases of the various tissues of the body. Each article has been prepared by one eminent in his special department, and is treated in a scientific, practical and exhaustive manner. The illustrations are worthy of all praise, the articles on gunshot wounds being illustrated by cuts furnished by the Surgeon General of the U. S. Army of specimens contained in the vast collection of the Army Medical Museum.

Since the beginning of this great encyclopedia, three men engaged as collaborators for the present volume have died: Otis, whose place is taken, and most admirably filled, by our own Conner, of Cincinnati; Hodge, whose article is written by Nancrede, of Philadelphia, and Hodgen, who had fortunately already completed his paper, on ulcers, before removed by death.

The foreign contributors to this volume are, Bryant, Cheyne, Grant, and Marsh.

Contributions to Practical Gynecology. By S. J. Donaldson, M. D., Surgeon to Gynecological Wards, Ward's Island Hospital, etc. Illustrated with sixteen wood engravings. New York: J. H. Vail & Co. Columbus, A. H. Smythe & Co. 8vo. Pp. 134. Paper.

We have here two Essays which the author read before the New York Medico-Chirurgical Society.

I. Practical Observations upon Uterine Deflections. In the first chapter the author criticises sharply, but justly, the plates representing the female pelvic organs as found in the text-books—including even Thomas' classic work. Then follows Dr. Donaldson's diagram, which is certainly an excellent one. For the treatment of prolapse and retroversion, he

uses his own modification of Cutter's pessary. He unhesitatingly condemns all forms of internal pessaries, for these affections.

For uterine flexions—which he discusses fully—he uses an elastic intra-uterine stem pessary, the stem being attached to the hard rubber vaginal part by an elastic band. He seems to have had good luck in the use of the stem pessary.

II. Practical observations upon Dysmenorrhea. His discussion of this subject is full and interesting. Where flexion exists he uses his stem pessary.

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HANN & ADAIR, Publishers, Columbus.

THE AMERICAN SURGICAL ASSOCIATION.

Three years ago the American Medical Association met at Atlanta, and among its oldest and most distinguished delegates, some had come by pre-arrangement to form a new society, to be known as the American Surgical Association. It was with no spirit of disaffection or conspiracy, for pre-existing societies had heaped upon them their highest honors and always given them a hearty welcome at the annual meetings. Those interested in the new enterprise were men rich in honors and achievements; men whose names, some of them at least, had grown familiar to two continents; men who were the founders of medical societies, had watched their progress and knew better than other men their object, power, limit, and possibilities; men who had struggled through the long years of obscurity to positions of merited prominence, and who, as teachers, authors

and surgeons knew the best for medical minds; men who had visited the old world and had been in the deliberations of the greatest European societies. Men like these had assembled at Atlanta to form a new surgical association that should be the crowning glory of their lives, one they could leave as a proud legacy to posterity, and one that should afford a worthy stimulus to the young, aspiring American surgeon.

Shall we ask the reasons for such a venture? Was it really to meet a want? Did not the county, state and national societies afford ample opportunity for the discussion of all surgical subjects? No; for the originators had long been members of these societies and had ceased to hope for a high standard of scientific and literary excellence in them. They had, indeed, created the surgical section of the great National Medical Society; but in this they had been disappointed, for ignorance and licensed charlatanism had worked their way to the highest honors, and merit wore no badges that arrogance had not successfully counterfeited. Yes; it was to meet a want. It was to be the fulfillment of a long-cherished dream—of a society of veteran surgeons, teachers and writers, met to discuss the profoundest surgical problems.

Well, they met, organized, and separated to meet at Coney Island in the following year. Their second meeting was a sad disappointment, and they again separated, inwardly dreading lest the little life that sea air could not invigorate should become extinct ere its third anniversary, which was to be held in Philadelphia, May 31, 1882. On the day appointed, in the College of Physicians, they were called to order by their venerable President. Delegates and visitors all told would hardly have made an average attendance of the county medical society; but an hour later, standing at the end of his spacious dining hall, packed with the devotees of learning and good eating, he called the eager crowd to order with loud thumps on the old door-knocker of Ephraim McDowell, saying: "Gentlemen, the American Surgical Association is an acknowledged success." True enough; they had just had an election and the *quota was full*. To say that members had been busy for months urging surgeons far and near to accept of membership, would be a breach of confidence. To say a word against a single man elected would be unprofessional, at least, for every new surgeon was either a 'hospital surgeon or a writer. But to say that in every town of five thousand inhabitants there is not a surgeon worthy of a position in the American Surgical Association, to say that one thousand surgeons under forty years of age could not be found in the United States, whose record as surgeons and writers is not

up to the virtual standard of the Association, is to deny to an interested spectator the average allowance of common sense.

If the gathering *was a success*, its distinctive features as the foremost American-Surgical Association (for such we take its aim to be), escaped the careful observer. Socially, it was a success. No delegates ever fared more sumptuously, and no hosts were ever more hospitable to stranger guests and friends.

But has this organization nothing better to boast of? Her quota full, but full of what? Men, who, from the standpoint of *experience*, can discuss the great problems of surgery? Writers from data furnished by *experience*? Hospital surgeons, who, with judgment matured by long years of experience, and strengthened in the richest fields of labor, can make declarations that shall be welcome in every part of the world?

Too easily frightened! Over-anxious to make the new enterprise an early success! Too impatient to fill the quota!

Better to have perished with the standard far advanced than achieve cheap laurels by shifting the standard to a point below the aim of moderate ambition. Better say with the king of beasts, "one, but a lion," than with the fox, to count a tribe on every hill-side.

BURDOCK FOR INVETERATE PSORIASIS.

In the September number of Dr. Squibb's *Ephemeris*, is a communication from Dr. W. C. Reiter, of Pittsburgh, Pa., in which he relates how he was himself cured, and had cured others, of psoriasis by the use of a tincture of the seeds of the common burdock—*Lappa major*. This disease, when stubborn, is so very stubborn that it gives ample time for experimentation, and the remedy now re-introduced by Dr. Reiter is so easily found and applied that it ought not to be long until its virtues are definitely established, or its claims shown to be false. We say "re-introduced," for the remedy has been long used in domestic practice in skin diseases.

The seeds can be gathered during October, usually. The plants should be shaken over a sheet, spread on the ground, or the heads may be pounded in a bag and the husks blown away with a bellows. The tincture should be made in the proportion of two ounces of seed to the pint of whisky. The seeds should first be crushed, or ground. The dose of the tincture (which should be made of the fresh seeds) is a tablespoonful three times a day. The remedy should be long used—for many months if necessary—but the results, according to Dr. R., will always

compensate. An essential oil and a resin seem to be the medicinal agents.

CALOMEL IN DIPHTHERIA.

In the communication of Dr. Reiter above referred to, he takes occasion to speak of another favorite line of treatment of his, namely, the treatment of diphtheria by large doses of calomel. Thus he gives to a child eight years old twenty grains of the drug to commence with, and ten grains every hour thereafter.

The doctor has a theory, of course, on which he bases his practice, which is that *diphtheria is a functional disease of the liver*, resulting in an increase, and final excess, of fibrin in the blood; and calomel he regards as a defibrinator.

We do not take any stock in Dr. Reiter's views of the pathology of diphtheria, and as to his *facts*—they can only be verified by a multitude of observers securing the same results at all times and under all circumstances. The literature of diphtheria, more than that of any other disease, is filled with accounts of wonderful sure-cures, based on the experience of single practitioners in a necessarily limited number of cases. A given locality may be visited by epidemic after epidemic of diphtheria (though undoubtedly many cases of simple follicular tonsilitis are frequently mistaken—sometimes intentionally—for the graver disease), of so mild a character that the cases uniformly recover. It is these epidemics that serve to develop the faith of the local practitioner in remedies whose inertness will be rudely demonstrated in some subsequent epidemic which shall decimate his patients.

Perhaps Dr. Reiter has found a specific; we hope he has; but for ourselves, we have not even a mustard seed of faith in it.

SPONTANEOUS EVOLUTION.—Dr. A. J. Foreman, of Montra, O., sends us a report of a case of spontaneous evolution, occurring in a multipara, of middle age, after a labor of about twelve hours. The child was dead; was a little over the average size.

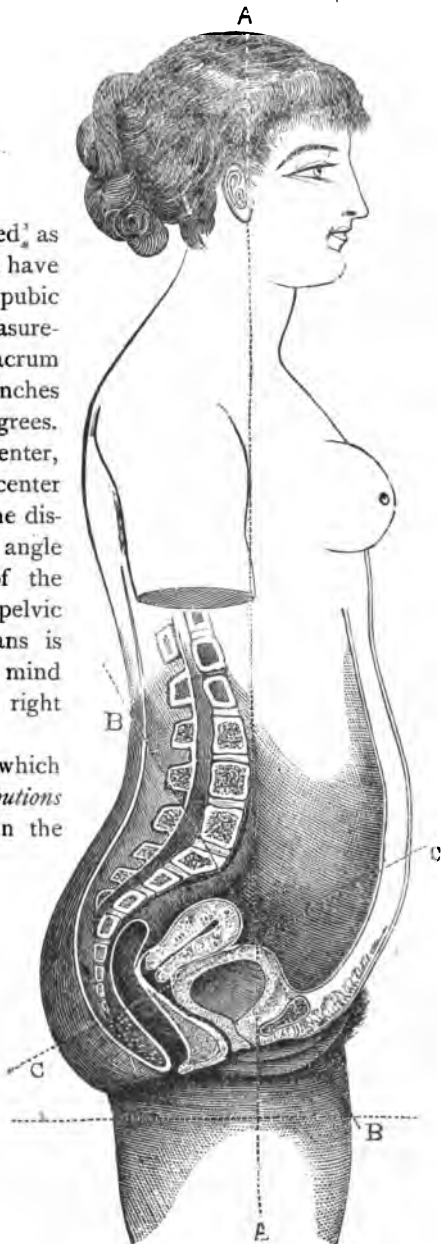
The meeting of the American Public Health Association, at Indianapolis last month, was a pronounced success. All sanitarians are admitted to membership, without regard to creed. Dr. Jas. E. Reeves, the editor of our West Virginia Department, which he has sadly neglected of late, was honored with election to the Vice Presidency. Our friend, Dr. Thos. L. Neal, the efficient health officer of Dayton, was made Chairman of the Executive Committee. The Association meets next year at Detroit.

The Normal Position of the Female Pelvic Organs.

We take pleasure in presenting to our readers a figure of the female form, in which the pelvic organs bear their proper relationship to the pelvis and to each other. The rectum is represented as moderately dilated, when it would have been better empty. Taking the pubic bone as the central point for measurements, the promontory of the sacrum will be found four and one-fourth inches from it at an angle of sixty-two degrees. Four and one-half inches from its center, at an angle of forty degrees, is the center of the sacral hollow. At the same distance from its lower border, at an angle of twelve degrees, is the tip of the coccyx. Having thus secured the pelvic outlines, the placing of the organs is comparatively simple, having in mind that the axis of the uterus is at right angles to that of the vagina.

A comparison of this figure (which we take from Donaldson's *Contributions to Gynecology*) with those given in the ordinary works on diseases of women—of which fig. 2, page 220, of our present issue is a fair sample—will sufficiently explain the difficulty the tyro experiences in trying to understand uterine displacements and the use of pessaries.

We commend the figure to the careful attention of all our readers, but especially to those who pay particular attention to the diseases of these organs.



PROFESSOR TALIAFERRO'S PAPER.

We have reprinted this paper almost in full. We have done this because we have tried his method, ever since it was introduced to the profession, over four years ago, and know its value. We have tried it in many cases, and can confirm all its originator claims for it.

In that part of the paper which we have not reprinted, its author calls attention to the attempt made by Bozeman, of New York, to appropriate his idea for himself. Dr. Taliaferro was undoubtedly the originator of this method of applying pressure to the uterus, and is justly entitled to all the honor which thus belongs to him. We are pleased to see him so vigorously and thoroughly vindicating his claim.

A NEW IDEA IN GASTROTOMY.—Dr. Felizet, (*Lancet*) after washing out the stomach with a tube, on the siphon principle, cut down to the stomach through the abdominal walls, after the usual method. He then connected the esophageal tube, which still remained *in situ*, with a vessel containing ether, which he then plunged into hot water. The vapor given off at once distended the stomach, so that he was enabled to incise the peritoneal layer, and stitch it to the abdominal womb, at his leisure and securely. He then, everything being in readiness, completed the operation by cutting through the remaining coats.

CORRECTION.—In Dr. Ikirt's article on Anesthetics, in our last issue, on page 150, line 14, instead of *alcohol* read *chloroform*.

OUR ADVERTISERS.

PHOSPHORUS has always held a prominent place in *malaria medica*, as a remedy in a large class of nervous affections, especially in those affections marked by loss of nerve power. Pharmacists have resorted to various devices to present the remedy in an acceptable form, and in a shape for physiological absorption and assimilation. The *Acid Phosphates* of Prof. Horsford seems to meet all the requirements. It is pleasant to the taste, acceptable to the stomach, agreeably stimulating in its primary effect, and highly tonic in its ultimate action. We have yet to meet with one who has been disappointed in its use.

AMONG sewing machines, the celebrated "Domestic," for family use, seems to take the lead; at least that is the opinion of the lady at, our elbow, who bases her statement on—how the years go by!—ten years of use. The agent in Columbus is Mr. F. D. Prouty, 19-23 East Long St.

COLUMBUS MEDICAL JOURNAL.—Supplement.

“The Columbus Medical College Imbroglia.”

OUR VINDICATION.

The Voice of the Medical Press.

Early in September, the writer sent a full series of the Imbroglia publications,—including Dr. J. W. Hamilton's original *Sunday Morning News* article, the writer's pamphlet (August supplement of JOURNAL), Dr. Hamilton's pamphlet, and the writer's brief rejoinder (September editorial,)—to the leading medical journals of the country. The documents were sent without comment, being merely numbered so as to be read consecutively. Both sides of the matter were therefore presented. Space forbids the full reproduction of all the editorials, or even brief selections from all; only the principal ones are therefore quoted. NO SINGLE JOURNAL HAS SOUGHT TO DEFEND THE SCHOOL. One journal thought the W. Va. State Board of Health had no business to go back of the diploma: the profession will look with some curiosity for an expression of opinion from that journal on the recent exposure of the “*Bellevue Medical College of Massachusetts*,” by the Illinois Board of Health.

[From Detroit Clinic, Sept. 27, 1882.]

“The shameful story of the internal rottenness of the Columbus Medical College is best told in the words of Dr. James E. Reeves, who, under the head of “Cheap Di-

plomas," recited it to the West Virginia State Medical Society.

* * * * *

"There is one thing we are sorry for every time we notice it; that is personal attacks of medical men published in the daily press. We believe that an injury is done to our profession every time such an article appears in the columns of the daily newspapers. Dr. Hamilton, of Columbus, used this unworthy channel to inform the inhabitants of that city of the treason (?), etc., of Dr. Baldwin. Why inform laymen of matters that belong properly before the medical profession?"

[From Maryland Medical Journal, Sept. 15, 1882.]

"'VIRTUE CANNOT LIVE OUT OF THE TEETH OF EMULATION.' We have received a printed communication, signed by *A. M. Dent, M. D.*, postmarked Parkersburg, charging that the action of the Secretary of the Board of Health of West Virginia, in passing upon the qualifications of that gentleman for registration, was influenced by personal spite and malice. On the back of this communication the following is written in pencil: '*In this State Reeves is considered a great fraud.*' We have read carefully everything bearing upon the matter of dispute between Drs. Reeves, Baldwin, Dent and the Columbus Medical College, and our minds are thoroughly satisfied as to the merits of the controversy. We will only say it is a pity there are not more such 'frauds.' There ought to be one such in every community—a man who has the courage to speak and to do."

[From Cincinnati Lancet and Clinic, Sept. 30, 1882.]

"Only recently a mill at Columbus was notified by a neighboring State Board of Health that for registration purposes its graduates would not be recognized."

[From Indiana Medical Journal, Sept., 1882.]

"* * * The graduation of men *on a four weeks' course of lectures*, and men who were as ignorant as Dr. Baldwin avers, is an insult to the profession, and it should resent it in a manner that would deter other colleges from engaging in such practices in the future.

"The charges brought against Dr. Baldwin, even if they were true, will not divert the attention of the profession from the main facts that the Columbus Medical College has grossly violated its obligations to the profession, perpetrated a great wrong upon those of its graduates who have earned their de-

grees by honest toil, and left a stain upon its diplomas which can never be effaced.

“* * * The graduation of such ignoramuses from any college, whether regular or irregular, demonstrates the necessity of stringent laws to regulate the practice of medicine, and the profession of Indiana should wake up to the absolute necessity of a united effort in the coming winter to secure the passage of a law that will give the powers that be authority to drive from the State the hundreds of quacks and scoundrels who call themselves doctors, and some of whom we regret to say have diplomas from respectable medical colleges. No wonder that the profession is sometimes brought into disgrace, when men are graduated in medicine who don't know what the iris is, nor the pupil; can not locate the mitral nor the tricuspid valves; place the valvulæ coniventes in the brain, and the ileo-cecal valve in the rectum. But for the present we dismiss the subject as Hamlet throws down the skull, ‘*pah!*’ ”

[From Philadelphia Medical News, Sept. 30, 1882.]

“THE MEDICAL DIPLOMA SCANDAL. — * * * There is, however, usually in these smaller cities one leading doctor who organizes a faculty from the material of the town, or of the neighborhood, an old warehouse is converted into a college building, and clinics chiefly surgical, and made up of the patients of the surgeon, are commenced, with the intention to advertise the great man as their real object.

* * * * *

The present scene of conflict is the Columbus Medical College. The history of the existing medical convulsion will serve to illustrate the nature of the others. If the present case did not involve some questions of high importance to the medical profession, we would be little disposed to give it prominence by recognition and discussion.

“In the present controversy we learn from the pamphlets that have been published that Dr. Baldwin, then a professor in the school, opposed the conferring by the Columbus Medical College of the degree of M. D. on a man who was graduated in a month after he matriculated, and whose antecedents were of an unsavory character. Dr. Baldwin united with Dr. Reeves, of West Virginia, in the exposure of these iniquitous practices. Dr. Hamilton, of the Columbus School, denounces Dr. Baldwin for his share in these laudable attempts to correct flagrant abuses. Every right-minded member of the medical profession looks on such exhibitions with unfeigned regret. Divested of all extraneous questions, such is the

status of this controversy, and although there have been ample time and opportunity, we regret to say that the authorities of the Columbus Medical College have failed to offer any satisfactory explanation of their action in the case under discussion, and the profession is therefore able to reach but one conclusion."

[From Independent Practitioner, Sept., 1882.]

"Numerous pamphlets have been disseminated relative to the Columbus (O.) Med. College difficulties. The following extract from a recent number of the *Maryland Medical Journal* is a concise account of the affair, with some practical comments."

[From Maryland Medical Journal, Sept., 1882.]

"A MODEL (?) INSTITUTION.—The revelations brought to light through the instrumentality of Dr. James E. Reeves, of Wheeling, in reference to a medical college located in Columbus, Ohio, and known as the 'Columbus Medical College,' are so damaging to its reputation that we can hardly see how it can survive the odium into which it has been cast by them. One of the faculty, Dr. J. F. Baldwin, declared that 'one man was graduated' from this institution 'who didn't know what the iris was, nor the pupil, could not locate the mitral nor tricuspid valves; placed the valvulæ conniventes in the *brain*, and the ileo-cecal valve in the *rectum*!'—adding 'there were several of that sort.' For this exposure it appears he was summarily ejected from his professorship. * * * * *

"We learn that the leading spirit of this so-called college is a Dr. Hamilton—the Professor of Surgery—who owns the college building and a majority of the stock, so that he elects his own trustees and through them causes himself to be elected Treasurer and Secretary of the Board, and be placed in charge of the building, and even of the dissecting material. Dr. B. also states that * * * there are no hospital or clinical advantages except a surgical clinic once weekly, no museum worthy of the name, none but the crudest means of instruction and only an ill-arranged college building. Yet this professes to be a *regular* college, and is a member of the 'American Medical College Association.'

"We have now in this city four medical colleges, with a prospect of a fifth in the not distant future. There will necessarily be a keen rivalry between some of these and the desire for large classes and success will prove a temptation to relax in the requirements relating to attendance, fees and ex-

aminations. Let us be doubly careful that no just ground for censure attach to us. Better that the colleges should perish than that the honor and usefulness of the profession should be sacrificed.

“ May heaven defend us from ever witnessing in this community such things, or any approach to them, as have been brought to light in Columbus. May no rivalry, no supposed necessity, no engrossing self-interest, induce the authorities of *our* colleges to make any such sacrifices of decency, principle, and morality.”

[From American Medical Weekly, Sept. 16, 1882.]

“ COLUMBUS MEDICAL COLLEGE IMBROGLIO.—A pamphlet with this title has been received from Dr. J. F. Baldwin, formerly connected with the above mentioned ill-starred and badly smirched Institution. * * *

“ A careful reading of this pamphlet shows that Dr. Baldwin has been foully treated; that his course was right and not wrong; that the Columbus Medical College is a disreputable Institution and not worthy of recognition; that it has been repudiated by the State Board of West Virginia; that Dr. James E. Reeves has acted handsomely, justly, fairly and independently; and that Dr. Hamilton, of the college named, and Dr. D. N. Kinsman, Dean (who declared that Dent had passed with ‘a high grade, particularly in obstetrics,’) have acted very badly indeed.”

“ Such a college has been justly and properly repudiated by the State board of West Virginia, and must, of course, be a stench in the nostrils of all corporate bodies and decent practitioners in the entire country.”

[From Detroit Lancet, Oct. 1882.]

“SOME OF THE INSIDE WORKINGS OF A ONE MAN MEDICAL COLLEGE.— * * * In a recent paper this gentleman, Dr. J. F. Baldwin, well known as the able editor of the COLUMBUS MEDICAL JOURNAL, makes a full exhibit of his relations to the case. * * *

“If all the statements shall prove to be capable of legal proof, the Columbus Medical College should be wiped out of existence, and the active participants in it denied the honors of an honest profession.” * * * “The statements of the other side do not at all mend matters.”

[From Pacific Medical Journal, Oct., 1882.]

“A VERY IRREGULAR REGULAR MEDICAL SCHOOL.—There are a few regular medical schools in the United States which

almost outstrip the poorest irregular ones in the faculty with which incompetent candidates are able to pass their graduating examination. Dr. Reeves * * * has discovered one such." * * * *

[From Philadelphia Medical and Surgical Reporter, October 7, 1882.]

"A MEDITATION ON MEDICAL COLLEGES.— * *

A poor man is generally despised, whether he deserves it or not, but a poor medical college always deserves it. No professional men have a right to band together to set on its legs an impecunious institution. The history of all such enterprises is a long list of jealousies and backbiting, degrading competition for students, wretchedly superficial instruction, deficient anatomical and clinical material, servility in lecturing, a sham of an examination, and a lot of grossly incompetent young men turned out to prey on the community as doctors.

"If by accident an honest man is on the faculty and exposes this miserable history, then comes a scene of slander and recrimination, which stains the whole profession with its inkiness.

"A lamentable example of the kind has been recently shown by the Columbus (Ohio) Medical College. It graduated a man after *three weeks* attending at lectures, and in the face of the remonstrance of at least one member of the faculty. The matter leaked out through the latter, and a vile anonymous attack upon him was made by another member of the faculty, *in the columns of a Sunday paper*, written at his request, it appears, by some attorney of the size for that sort of work. * * * *

"There are always in this country a large body of men who are poor and ill-educated, and yet who want the degree of M. D. These are always on the lookout where they can obtain it at the least expenditure of time, brains and money."

[The large class now in attendance at the Columbus Medical College, cannot but be regarded as the direct fulfilment of the statement contained in the last paragraph above. It would undoubtedly be incorrect to state that all these students came in response to the free advertisements given this school during the summer; but the virtuous ones are in bad company, and it is to be greatly feared that they will, next spring, find it difficult to clear themselves from suspicion. This is all the more certain from the fact that—the mal-odor of one attaching itself to both—respectable students have so far

shunned the city, that Starling Medical College, with an untarnished reputation and with fine hospital and equipments, has had a falling off of half its class. The contrast is a striking commentary on the state of medical education, and of professional requirements, in the west, and demonstrates the absolute necessity of State Health Boards, with authority to protect the people.—J. F. B.]

[From Baltimore Medical Chronicle, Nov., 1882.]

“THE COLUMBUS MEDICAL COLLEGE SCANDAL. * *
It may be readily supposed that so judicious an official as Dr. Reeves would not proceed to such an apparently severe measure unless supported by the strongest evidence. This evidence, hitherto unimpeached, was furnished by Prof. J. F. Baldwin, a member of the faculty of the disgraced college, for which act of “treason” the Professor was expelled. We are disposed to believe that the expulsion did not hurt the feelings of Dr. Baldwin very much. However, the officials of the college have since resorted to the most undignified methods of attacking both Dr. Baldwin and Dr. Reeves, for their manly stand in defence of honorable methods in medical education. We have been placed in possession of a number of publications containing the statements of both parties to the dispute, and are obliged to say that it is not very delectable reading. Dr. Baldwin while giving his traducers some very sharp thrusts, and exposing the disreputable methods of the college, is at the same time cool and parliamentary in speech. The President of the College, Dr. J. W. Hamilton, on the other hand, attacked Dr. Baldwin through the columns of the daily newspapers, and characterized him as “a spy, informer and traitor,” “utterly unworthy of association with honorable gentlemen,” “failing to distinguish between *meum* and *tuum*,” etc., etc. Dr. Hamilton confesses that the newspaper attack on Dr. Baldwin was made under legal advice. The advice seems to have been given on the principle: When you have no case, abuse your opponent. No evidence is offered to sustain the charges against Dr. Baldwin’s character, and the presumption is that they have no basis whatever. On the whole, we rather feel like congratulating Dr. Baldwin on his retirement from such an institution as the Columbus Medical College has been shown to be, and we trust Dr. Reeves and the State Board of West Virginia will not back down from the stand they have taken against dishonest methods in medical education.”

[From Louisville Medical Herald, Nov., 1882.]

“The Columbus Medical College has since that time felt called upon to make an attempt to defend its action; but it will be a long time before it can succeed in breaking the force of Dr. Reeves' brief statement of facts.”

[From New England Medical Monthly, Nov., 1882.]

“THE COLUMBUS MEDICAL COLLEGE IMBROGLIO.—We wonder whether, when Dr. Reeves made his famous speech, showing up the Columbus Medical College, he thought of the precious row he was about creating? If the facts are as stated in this pamphlet of Dr. Baldwin, and we have no doubt of their truthfulness, the Columbus Medical College is doomed. Such a state of affairs should not exist, and the profession of Ohio owe it to themselves and to their professional brothers of other States, to purify that school and thoroughly disinfect it. As Dr. Reeves is largely interested in sanitary matters, we would respectfully suggest that the process of disinfection be left to him. He is perfectly competent to do it and do it well.”

[From Cincinnati Lancet and Clinic, Oct. 21, 1882.]

“COLUMBUS MEDICAL COLLEGE.—This institution with its phenomenal faculty, its phenomenal course of study, phenomenal examinations, and phenomenal way of granting diplomas, is getting the benefit of a good deal of gratuitous advertising. In fact, nearly the whole medical press has commented on its disreputable doings, until it seems to be placed on a plane but little above the infamous Buchanan College of Philadelphia.”

[From New York Medical Record, Nov. 4, 1882.]

“COLUMBUS MEDICAL COLLEGE.—The discussion about this college has been kept up very actively in our various exchanges. There seems to be but one opinion as to the character of the college—that it was but little better than Buchanan's diploma mill.”

The stigma which has been placed, by the action of this College, upon the holders of its honestly earned diplomas—and there are many such, is deeply deplored by me, but the responsibility must be placed where it belongs, with the officers of the school.

Respectfully submitted,

J. F. BALDWIN.

COLUMBUS, O., Dec. 1, 1882.

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COMMUNICATIONS.

THE MEDICAL PROFESSION AND THE MEDICAL SCHOOLS.

BY C. SIHLER, M. D., PH. D., CLEVELAND, OHIO.

The medical profession has, for reasons difficult to understand, allowed the control of admission into its ranks to pass out of its hands into those of the medical colleges, and the outcome has been, that admission has become almost a farce, if not a fraud and humbug. What can be done to remedy this evil?

To prove the statement, and to answer the query, is the purpose of the following paper.

To learn the shoe-maker's trade, a boy is expected to spend three years at work, all day, and every day, and all the time under the supervision of his master. Now compare, please, the manual skill, merely, which a physician ought to possess, with that of a shoe-maker. But the physician needs to have other organs trained besides the hands and eyes. He must know the healthy human body, its structure, and the functions and actions of the different organs. Not only must he know this normal condition, but he must equally understand their innumerable disturbed actions, which will call for his aid as physician, surgeon, or obstetrician. He must also comprehend the means at his disposal of relief and cure, to say nothing of the etiology and prevention of disease. In other words, let any one take up the ordinary works on practice, surgery and obstetrics, and glance over the names and numbers of diseases, injuries and

difficulties which must be objects of the physician's study, and set beside these—a pair of boots!

The young man who has spent three years in learning to make a pair of boots, deserves more to be called out by the dean of the shoe-maker faculty in some church or opera house, and to be presented with a diploma and boquets, than does the medical student who has heard thirty-six lectures a week for five months, two times, and slashed away at a subject in a way known only to those who have seen it. It is probable that the shoe-maker boy has learned his trade, while, as far as the college is concerned, it is probable that the medical student has not learned his craft at all. And why not? Because, although the number of institutions promising to fit out young men for the medical profession is large, sadly large, the quality of these institutions is low, sadly low. They are sadly inadequate to the work they have undertaken, as every one will confess who has been within their walls and has had the benefit of their training, especially after he has learned, by attending other schools, what a good school really is and ought to be. If, then, medical schools promise and profess to do what they cannot and intend not to do, are we not justified in calling such, frauds and hum-bugs?

These may seem hard epithets, but they are just what the American medical colleges deserve, with but a few exceptions (e. g. Harvard, Pennsylvania University, College of Physicians and Surgeons, New York). Any man of judgment will say so, who knows anything about them, and if any one wishes to convince himself, let him send for their circulars, and he will find that their own circulars will condemn them, although these documents are drawn up by, and in the interest of these institutions themselves. What might be the verdict if other, and disinterested, parties were to give a description of the facilities of these same schools!

The points needing criticism have often enough been pointed out. There is no care taken, whatever, in admitting the proper men. The methods of instruction are abominable—even barbarous. No one can teach chemistry and physiology by lectures, merely. No man can do his dissections while attending thirty-five lectures a week, and reading up for them. No town of 10,000 or 25,000 inhabitants can furnish enough clinical material for a graduating class of fifty or seventy-five men, even if there be a three years' course. No student can learn from clinical lectures, if sitting with three hundred men in a room and not allowed to watch cases from day to day and examine for himself. Further, the

different grades of students are thrown together into one mass to hear the same lectures. The number of students is by far too large for the facilities of instruction. The time in which the necessary knowledge is to be acquired is too short. Thirty-five lectures a week are an outrage on any ordinary human being. I shall say nothing about the character of the lectures; they can be nothing but text books copied; nothing more can be expected from many of those "filling the chairs"—can one gather grapes from a thistle, or milk from a calf? Finally, the examinations are conducted by the professors themselves, almost exclusively, who have been the teachers, and are directly interested in the graduation of the student.

That the foregoing remarks may not seem empty invectives, I give, first, a list of studies which, according to Professor Billroth, of Vienna, should be considered a minimum for a medical practitioner; secondly, the course proposed by the Harvard Medical School, which is a model for American schools; and, thirdly, some extracts from a catalogue of an ordinary medical school.

Billroth, in his *Lehren und Lernen der Medicinischen Wissenschaften*, says: "The extent of the lectures and practical courses should be regulated in about the following way: Chemistry, with short practical courses, 6 hours (per week); Physics, 4 hours; Zoology and Comparative Anatomy, 3 hours; Mineralogy and Geology, 2 hours; Anatomy and Histology, with directions in working, 10 hours; Physiology, with short practical exercises, 8 hours; General Pathology and Pathological Anatomy, with practical exercises, 6 hours; all continued throughout one year. Pharmacology, Toxicology, etc., 4 hours, for one-half year. Special Pathology and Medical Clinic, with courses in physical examination, 10 hours for two years; General and Special Surgery, surgical clinics, with practical courses in bandaging and operations on the cadaver, 10 hours for one year; Obstetric Clinic, 3 hours, one year; Eye and Ear Clinic, 4 hours, one year; State Medicine, 4 hours, one-half year."

I hope it may not seem presumptuous on my part if I think that this course seems too extensive—that is, that the number of subjects is too large. This seems also to be the opinion of Prof. Huxley, expressed in an oration delivered by him at the Johns Hopkins University.

I next give a very brief account of the Harvard course, which would appear to me a model course, for our country certainly.

At Harvard the student is expected to have some knowledge of either

French, German or Latin, and of Physics (not to mention an ordinary English education). The course is one of three years; three times nine months being devoted to studies. It is also a graded course. In the first year are studied Anatomy, 4-5 lectures per week, Physiology, 4-5 lectures and recitations per week, and General Chemistry, 2-3 lectures and recitations per week. The Anatomy lectures are of course supplemented by dissection, as are the lectures on Chemistry and Physiology by laboratory work, which latter is obligatory as much as the purely didactic parts of the course. At the end of the year the student is examined in these branches.

In the second year the following studies are pursued: Pathological Anatomy, 4-5 hours; Medical Chemistry, 2 hours; *Materia Medica*, 1 hour; Surgery, 5 hours; Practice, 5 hours; Auscultation and Percussion, 3 hours, per week. At the end of the second year there are examinations in the first three subjects mentioned. "No student shall advance with his class, or be admitted to advanced standing, until he has passed the required examination in the studies of the year, or a majority of them; nor shall he become a member of the third class until he has passed all the examinations of the first in addition to a majority of those of the second year."

In the third year the following studies are pursued: Diseases of Eye and Ear, 3-4 hours; Practice, 10 hours; Surgery, 7-9 hours; (Dermatology and Nervous diseases are included under the two heads just mentioned;) Obstetrics and Gynecology, 3-5 hours; Therapeutics, 3 hours, per week. Hygiene is also taught.

Here we have, I think, a most excellent curriculum; judicious not only in paying attention to the essentials, but also in excluding what is not essential, and what must necessarily be, taking the powers of the human mind in consideration, positively injurious. It is rational by dividing up the subjects and by excluding the beginners from the higher courses which they can only partially appreciate; it is wise by distributing the examinations, which is a stimulus for steady and unremitting work and avoids the evil of cramming.

The catalogue states further that there were treated in the City Hospital, the Massachusetts General Hospital, etc., 6,181 cases in the wards, and 68,662 cases in the various out-door departments, and that the number of students was, in the first-class, 104, and in the second class, 69; in the third class, 55; in the fourth, 1, and graduate students, 11. I have given the hospital advantages, which are not all stated, to show the ratio

of students and patients. We see here that 136 students have the advantage of the number and variety of cases given above, *while there are schools where there is certainly not one patient for 2 or 3 students.* This is a very important point indeed. According to the numbers given, there could not be more than 55 graduates from Harvard in the last year.

Now, for comparison let us glance at a catalogue from another school. It is of little consequence from which institution; they are all very much alike. The one before me is from a Western town of 50,000 inhabitants, and there is a second school there. I do not wish to mention names, because I do not want to be personal.

Instead of such a paragraph as "Requisites for Admission," we find: "*Students arriving in the city should bear in mind that there are two medical schools in X; one is the, located on street; in other words, 'the old school.'* Students can be readily directed to this point and find it without difficulty."

Under the head of teaching we find "five lectures are delivered daily." No comments are necessary here. Under hospital and clinical instruction we read the statement: "The hospital building has a frontage of 154 feet, with other dimensions in proportion." One should like to know whether they give the long or short side, when giving these figures. It would be very desirable to know, from other sources than the schools themselves, how many patients were treated by them, and how many beds there are occupied regularly, and at the disposition of the teacher and student. The number of students in this school was 280, and the number of graduates was 114. Where and how 114 men could receive an adequate training in twice 5 months, in a place of 50,000, where there is a second school, in a hospital the second and third dimensions of which are not known, etc., is simply incomprehensible, and if tradition and custom did not sometimes make practices justifiable, one could not understand how Professors of such institutions can sign diplomas with any satisfaction, or even self-respect.

I have now to answer the question, what can be done to remedy this evil, and who can do it?

I answer, not the public, through its legislature, but the profession. The profession knows its own wants better than any one else. The medical profession as a body should do nothing more nor less than to assert and execute the rights and privileges which, at the present time, have been assumed and usurped all over the United States by clubs of men (often of eminence, ability and fitness, it is true,) calling themselves

"professors," and deciding who shall enter the profession, without asking the profession if it is willing to agree to their acts and decisions or not; a piece of impudence unparalleled in any other department. Certainly the lawyers do not permit such self-constituted bodies to usurp in their department the power to say who shall be admitted to the bar.

It is the right and privilege of the profession :

1. To decide upon what the standard for their members shall be.
2. To supervise the schools and their teaching, and the founding of new schools.
3. To take into their hands (together with the teachers) the examinations for admission into the profession.

The profession should have a word to say in the examinations, for two reasons: First, they ought to have a voice in deciding upon who shall be their equals, and enjoy their rights and privileges. Second, it is a fundamental moral principle, that no one ought to be a judge in his own case. The schools ought, even if their training were first-class and above suspicion, to invite outsiders to inspect and criticise their work if need be. Why do not the schools invite the State Society to participate in their examinations?

Although it would be a step forward if the profession would participate in the examinations, still the root of the evil would not be reached. It is not enough that a candidate has knowledge and is able to answer questions; it is just as important to know by what methods he acquired such proficiency, and how much time he spent in his studies. Who would be admitted to an academical degree in chemistry, physics or astronomy, if he had not worked for some time in a laboratory or observatory?

To a minimum degree this principle is recognized in the medical examinations. Every candidate is expected to have dissected for himself. Why are not similar requirements made in Physiology, Chemistry, and the other branches? The Professors of the Colleges, I suppose, would say: We have not the facilities. To which I would say: Then you have no right to exist.

It is of course not my business, nor is it the place here, to take up the special branches, and to lay down how each ought to be taught. Indications may, however, be gathered from the list of Billroth.

Not only should the teaching and instructions in the existing schools be supervised, but the profession should not allow new schools to be chartered without their consent and approbation.

It will be noticed that nothing whatever has been demanded but what is the natural right, so to say, of our profession. Why should Dr. A. B., together with C. D., his friend, and a few more, assume the right to say : You forty or fifty men are now Doctors, after you have listened to the learned lectures of the most gifted and powerful minds for the last five months, and after you have gone through the same thing just twelve months ago, the medical profession standing there like a herd of sheep and looking on. No, the medical men should not stand there like a herd of sheep, they should act as men, as rational men, *they* should say who shall be their comrades.

I think the profession should appoint a *Permanent Board*, clothed with authority and power to watch over the interests of the profession. Their duties would be, to keep a constant eye on the way the instruction is carried on in the colleges, to note of what kind of material the students are, how each branch is handled, how much time is spent, what the facilities for instruction are, what the extent of the course, what the proportion of students to instructors, and what the number of beds for each student. The last point seems especially important to me, because the number of patients would serve as a most natural balancing wheel for the rate of turning out doctors. If a school has none or few, it has no right to exist; while if its facilities are mediocré, it should turn out a small number, such a number only as could be educated with the means at hand.

The second duty of this Board would be to act as *Examiners in conjunction with the Professors*.

The third duty would be to act as *Registrars, and as Examining Board* for persons coming from other states and countries.

The fourth duty would be to *watch legislation*, and to enforce the laws made for the protection of the profession.

The next question is, how are we to get this board? Some will say, have it appointed by the Governor. I say no; we want no government interference nor help at all. I am a strong believer in the English system of taking care of yourself, and of letting every person, corporation, and profession take care of its own interests.

The members of a state society pay an annual due, which is largely expended in having the Transactions printed. This money would be far better employed in paying the board proposed. If the money levied is not sufficient, let us pay a little more, for it would pay; and if the physicians of one state are not strong enough, let two states, or natural groups of states, unite to form a powerful corporation.

From the legislature no aid in the shape of subsidies is required; the only protection which we demand from it is a title, *e. g.*, "Registered Physician," which no one shall be allowed to place over his door, or attach to his name, except he has passed the examinations and paid his annual dues; and the use of this title by others shall be a *criminal* offence, to be punished by the State. Thus the community would have a sign by which to distinguish the men that have made legitimate and sufficient preparation for practicing, from those that have not, and that is all the profession is entitled to. I am emphatically against the so-called quack laws, preventing such and such persons from practicing. Every man should have the liberty to put his body in the hands he sees fit, as much as his soul, and all the laws against quackery are unjust as well as impracticable. The proposed measures are, further, not revolutionary, nor do they interfere with the liberty of anybody. If any one wishes to teach, or a half dozen wish to fill chairs, let them do so to their hearts' content, but let them not have the impudence to say that on account of their valuable instructions certain men shall now be members of the medical profession.

Let me now point out a few of the advantages of such a measure:—

(1.) While liberal bequests have been made in the United States for the advancement of learning, not many have been made to aid the medical sciences proper. If, however, persons of benevolence and means were sure that their money would be used to prosecute faithful, good and unselfish work, money would be left just as well for medical schools for the relief of human suffering, as for schools for the study of Greek and Latin.

(2.) Men who "run the schools" merely as a means of advertising themselves, without having any special interest in the work of teaching, and without having prepared themselves for such a task, would be forced out of their positions and the grade of the surviving schools would be elevated.

As matters are now conducted, the Professors are of course continually advertising themselves through their catalogues and students, but are very strict with other folks that they do not do the same thing in some other way. I do not see how a professor of a medical school can be on the committee on "Medical Ethics," and yet such seems to be the case. Too much of the most vulgar kind of Phariseism here.

Further, the measures here indicated will tend to break up a certain number of the poorest schools, because the Board will of course not be

able to find their teaching capacity sufficient; they will force schools to unite in places where there is scarcely room and material for one, and compel those left to do honest work, by not permitting them to graduate a number greater than their facilities of instruction will permit.

As regards the system of preceptorship, this time-honored institution, it seems to me, is of little value as now conducted. Nevertheless, it includes some very valuable features, and should be retained. In hospital practice one has a chance to observe certain classes of diseases and certain stages of diseases only, and fails to see diseases and stages of disease which are very frequent in private practice. There is a certain something included under the head of *tact*, which cannot be acquired by reading books, and which will not be apt to grow in hospital practice, but which it is necessary to have. By serving under a practitioner, these deficiencies may be remedied, and I think a young man should study with a preceptor for a year or so after he has finished his studies at the medical school. After the expiration of this year he might be entered on the register.

I have written the above without any expectation that the plans suggested will be adopted. Medical Societies, from the County Society to the American Medical Association, seem rather impotent bodies. I suppose we shall have to wait for Boards of Health to take these matters in hand; but these bodies will be products of politics, and hence not to be hailed with unmixed joy.

*PANOPHTHALMITIS FOLLOWING THE LODGMENT OF
A PISTOL CARTRIDGE-SHELL WITHIN THE
EYE-BALL; ENUCLEATION, &C.*

BY D. W. GREENE, M. D., DAYTON, OHIO.

Dr. S. was wounded in the right eye by the accidental discharge of a cartridge which he was endeavoring to place in the cylinder of a revolver. The ball struck the floor, where it was afterward found, but the shell flew in the direction of least resistance, which, unfortunately, was in the direction of the Doctor's eye. I saw him five hours after the accident. There was a ragged, circular wound in the center of the upper lid, about one line from its free margin. This wound was $\frac{1}{4}$ inch in diameter, and corresponding to it in position, there was a triangular valve-like wound of the eye-ball, the apex looking forward and ending at the sclero-cornea.

I.—6.—2.

junction, each side of which would have measured about one line. The eye was reddened, but was not painful. The anterior chamber was full of blood, which precluded the possibility of an examination by oblique illumination, or with the ophthalmoscope. $V=^{\circ} 7-1$ (Bowman). The impossibility of using these two valuable aids to diagnosis was greatly regretted, because their employment (had the media been clear), would have revealed the presence of the shell in the vitreous body.

The very small size, and apparently insignificant nature of the wound of entrance, made it difficult to conceive of the possibility of so large a body as a 22-100 cal. cartridge shell having passed into the eye. Two other facts conspired to deepen the doubt: 1st. There was another small wound of the same lid, but higher up; just below the supra-orbital ridge. 2d. The Doctor was very positive that the position in which he stood at the time of the accident would have utterly precluded the possibility of the shell having entered the eye. I sprung the valve-like wound in the globe, and with a probe searched carefully for the foreign body. I failed to detect its presence, as did also his brother, Dr. Lee Spitler, of this city. He was advised to rest in bed, and have cold applications made to the eye. The following day he had very little pain, but there was marked conjunctival and sub-conjunctival injection, together with great photophobia and lacrymation. These symptoms continued with increasing severity, and on the morning of the fourth day there was great chemotic swelling of the ocular conjunctiva, the cornea began to look hazy and dull, and a necrotic process began at its lower border, and spread rapidly over its whole surface, involving its entire structure, except the posterior elastic lamina, (Membrane of Descemet) which now bulged up from the crater-like excavation. At this time severe pain was felt, the first since the accident (seven days before). The advent of panophthalmitis being thus plainly announced, I advised an immediate enucleation, which was refused. He was then advised to use hot applications. These gave him so much relief that he insisted on returning home. I was summoned by telegraph on the following Sunday evening to see him, and learned that since his return home he had been so tortured with pain that heat was of no avail, and he only got relief after there had been a free discharge from the wound in the globe. This respite from pain, however, proved of short duration, so that at the time of my visit he was again suffering acutely. I advised morphia hypodermically, and poultices to the eye. Saw him the following day, when I went prepared to enucleate the sightless and painful globe, which I proceeded to do, assisted by Drs.

Weaver and Spittler, of this city. The globe was so soft and yielding that it was only after a long and embarrassing trial that I succeeded. During the operation the point of the strabismus hook slipped into the wound of the sclera and came in contact with a metallic body which, on extraction, proved to be the cartridge shell, measuring $\frac{1}{2}$ -inch in length, by $\frac{1}{4}$ -inch in diameter.

I have been induced to report this case *in extenso*, not because of its extreme rarity, pathologically considered, for such are of lamentable frequency of late years, but rather because it contains a few points, which, while familiar to most medical men, are liable to misinterpretation, and their pathological significance underestimated. Cases have been reported, from time to time, of missiles entering the eye and being retained there, which at first gave no evidence of their presence, save the existence of an insignificant wound of entrance. Dr. Williams, of Cincinnati, has reported the case of an eye, injured by bird shot, where one wound only could be found. The eye was afterward enucleated, and three shot were found within it. One year ago, I saw a case, in the New York Eye and Ear Infirmary, in which the left eye of a day laborer had been injured by the premature discharge of a blast; there was an irregular wound, just behind the corneo-scleral junction, in the upper temporal quadrant, about a line in length, but nothing about it indicated that a scale of stone had passed into the eye. In fact, it resembled a bruise far more than an incised wound. The pupil was contracted, the media were clear, the unwounded lens was in its proper position, and the visual field contracted in the lower nasal quadrant. The case was examined by several members of the staff, all competent oculists, and while all agreed as to the probability of the missile being in the eye, no one, if I remember correctly, was able to outline it or locate it in the vitreous body. Dr. Noyes, after a thorough and painstaking examination, diagnosed its presence and location, both of which were subsequently confirmed after the eye had been removed. This fragment was three lines in length, and two lines in breadth, yet it entered his eye by a wound so small as to appear trifling and insignificant.

In the cases related, there was no relation between the size of the missile and the wound of entrance, and the lesson to be drawn from these (and from many others that have been reported, but which the limits of this paper will not admit), is, that no wound of the sclera should be lightly considered, *even if it be small*, because we cannot by any process of reasoning determine from a scleral wound either the size or nature of an invading body.

104 S. Ludlow St.

ACEPHALOUS MONSTERS.

BY L. WOODRUFF, M. D., ALTON, OHIO.

Congenital anomalies of conformation occur frequently in man and animals, and monstrosities are even more common in the vegetable than in the animal kingdom.

The interest in the cases I have to report grows out of the fact that the subjects were all born of one mother, within a period of less than six years, and occurred in the experience of one physician.

In March, 1872, I was called to see an infant a few weeks old, of Mrs. X. The child was in convulsions, and died a few hours after I saw it. My attention was called to a huge spina bifida in the lumbar region.

On the 8th of May, 1873, I was called to attend Mrs. X, in her sixth confinement. Labor progressed favorably, the feet presenting, and resulted in the birth of a female child of good proportions generally, but with entire absence of cranial vault, the cervical vertebræ terminating abruptly, and there being no bone above the superciliary ridges. There were rudimentary ears, the facial features were somewhat distorted, and the chin seemed to rest upon the top of the sternum.

On the 4th of May, 1874, Mrs. X was again confined, and after a short and easy labor was delivered of a well developed female child. Again, on the 5th of January, 1878, I attended her, when she gave birth to a male child, without cranial vault, and the exact counterpart of the one born on the 4th of May, 1874. Another child has since been added to the family without deformity of any kind. The family now consists of five children, all without any defect or malformation, and of fair intellectual development. The family is pleasantly and comfortably circumstanced, and I hear no history of previous deformities. The mother has no solution, conjectural or otherwise, of the matter.

Acephalous children are rare, considering the whole number of births, yet the arrest of development of the cranial bones is not more remarkable than that of the vertebræ in spina bifida, and need not excite greater astonishment.

It is difficult for me to believe that the "mother's fancy can have any effect—as to sex or likeness—during a fecundating copulation," and it is even more difficult to believe that "if she be shocked during pregnancy at the sight of one deformed, a child will be born of like deformity." It is much more easy to regard the coincidence as accidental, or to say that the nerve or blood-vessel supplying the part was wanting, and that there was consequent arrest of cell proliferation, and even then we are unable to explain the cause of the deficiency of such nervous or vascular supply.

RESPONSIBILITY IN PRESCRIPTIONS.

IS THE PHYSICIAN RESPONSIBLE FOR ACCIDENTS OF A POISONOUS NATURE, DUE TO NOT PUTTING THE DOSE ON PRESCRIPTIONS?

BY C. M. MILLER, MANSFIELD, OHIO.

In answering this query I do not wish to assume the role of judge and jury, but to express my humble opinion.

We are all well aware of the fact that many prescriptions are presented on which no directions are given, or only the phrase "Use as directed," which is just as indefinite, and leaves us in precisely as dangerous a position, giving us to understand in both instances that the patient, or some one connected with him, understands all about their administration. Many of you have often thought, "I don't like to put that prescription up, and would feel more safe if I knew how it was going to be used." You feel at the same time that the physician is not doing you justice by neglecting to put the directions on. When such a prescription is presented and the party asks how it is to be used, we are obliged to say "I don't know" (but in our own minds would say, I hope for their own good it will be properly used); or we say to them that the doctor undoubtedly told the patient how to use it. This position is very unsatisfactory and very dangerous, especially when we consider ourselves in the position of druggists, middlemen, to correct the errors in doses, etc., of the physician. But to answer the query. I should consider the physician responsible for mistakes occurring in this way, and my reasons are as follows:

There is no competent druggist who will dispense a prescription in which the dose is too large. In this way the M. D. has a safe-guard, and should take advantage of it by placing the directions on the prescription.

Then liniments and diuretics are often prescribed together with the directions "Use as directed," or both or no directions on either. The diuretic may be an emulsion and the liniment a saponified oil, which look very much alike. The liniment may contain a considerable quantity of aconite, and the patient may take a dose of the liniment instead of the diuretic. Had the directions been written on the label the patient would have read them. If the patient neglects to read them, he shoulders the mistake. Some would say the odor would distinguish them, but the patient does not smell first, and if he did he is not familiar

with drugs. The diuretic might contain spirits of turpentine, and then it might be called the liniment, or *vice versa*.

Physicians often leave verbal directions with some one at the house of the patient as to the dose and frequency of the medicine, but the nurse is suddenly called away and some one else is asked to administer the medicine. They see no directions and ask the patient the quantity taken at a dose, and the patient says a tablespoonful when the dose should have been a teaspoonful, and the dose taken is fatal. Now I am sure you will agree with me that if this bottle had been properly labelled this mistake would not have occurred. I can relate a circumstance which occurred in the neighborhood in which I live :

Dr. A. prescribed tincture digitalis in a solution for his patient, who had some heart trouble. In three days he again visited the patient, who did not seem to improve on teaspoonful doses of the medicine properly prepared. The doctor then told his patient he would prescribe other medicine, which he did, and gave the man and his wife verbal directions as to its use, but gave no directions on the prescription. He also told his patient to use it with great care. He told them of the dangers of the increase of symptoms, which scared them. They took the prescription to the drug store; the prescription contained tincture verat. vir., etc., The first dose, which was ten drops, was properly given. At midnight he awoke his wife and told her he was feeling bad, and advised her to give him a dose of the first medicine, as that seemed to relieve him most. The wife did as directed, she examined both bottles, which were of the same size, both with the same label, and gave her husband the wrong medicine, which produced death. Had these bottles both been properly directed this mistake would not have occurred.

A prescription, as follows, was taken to my store :

R. Chloral hydrate I oz.

Aq. cinnamon.

Syr. simpl., aa..... I oz. M.

Sig.—Use as directed.

The daughter of the physician presented the prescription, and said she wanted it prepared at once. I took the prescription back to the physician and asked him whether it was correct, when he changed the ounce to one drachm, and thanked me very kindly for my trouble. I did not know what use he intended it for, but thought the safest way was to return it. He told me he had told his patient to take a tablespoonful every three

hours unless resting. This kind of a mistake is liable to occur at any time, and a physician can do well to let the druggist see the dose, as it doubly insures the safety of medicines. There are a great many examples that could be brought to bear on this subject, but it is hardly necessary to mention any more here. Some physicians say they do not wish the druggist to know the directions. I am sure an honorable druggist will not take advantage of his patron, even if it is in his power to do so.

In my own mind I feel that when a medicine is prescribed, and the directions are not given, the physicians would have the whole blame when a mistake occurs. The druggist has done his duty in compounding, and should not be held responsible in any way.

TO DISGUISE THE TASTE OF QUININE.

BY J. F. BALDWIN, M. D., COLUMBUS, O.

While it occasionally happens that it is desirable to give the patient the full benefit of all the bitterness of quinine, the reverse is most frequently the case, and universally so when the medicine is to be given to children.

During the last eight years, I have tried everything that has been recommended, during that period, to cover the taste of quinine, and until recently have failed to find the desired vehicle. Some that I have tried have really increased the bitterness, as, for instance, the sweet spirit of nitre, which was recommended by some ageustic individual about five years ago, whose recommendation was copied—presumably before being acted upon—by all the medical editors in the country.

Various preparations have been devised that cover the taste for a few hours, but after standing over night the bitterness comes to thoroughly permeate the vehicle and disgust the patient. Preparations containing licorice will thus act, and I have lately taken advantage of this by prescribing the quinine in powders, and fluid extract of licorice and syrup in a bottle—making an ounce of the mixture to every eight powders—and directing that a powder be mixed with a teaspoonful of the licorice syrup at the moment of administration, to be followed by a drink of water to wash the syrup out of the mouth before the suspended quinine becomes dissolved in the saliva. Or, the vehicle may be prepared in a domestic way, by boiling about an inch of the ordinary black licorice stick in a

teacupful of water, and adding enough sugar to make a syrup. Children like this syrup, and by giving them a teaspoonful at intervals they will take it unsuspectingly with the quinine added and will never discover the difference.

A few weeks ago, however, an agent of the Burroughs Bros., of Baltimore, called my attention to a fluid extract of licorice which they manufacture especially for quinine mixtures. The ordinary fluid extract forms with quinine a resinous, insoluble mass, which remains firmly adherent to the bottom of the bottle. Burroughs' extract is made by a process which removes this resinous principle, so that the quinine is held in permanent suspension. (Burroughs Bros. make the ordinary fluid extract of licorice as well, so that it is necessary to indicate that made "for quinine" in the prescription, although the druggist should know what is meant even if not specially directed.) The proper proportions are indicated by

R Quiniæ sulphatis, ...	gr. viij.
Fl. ext. glycyr. (Burroughs'), ...	3j.
Syrupi, ...	3vij. M.

As indicating the real value of this combination, I may be allowed to relate a somewhat amusing episode of recent occurrence.

An urbane and gentlemanly agent of a manufacturing house, called on me to show and extol his wares, especially his fluid extracts. He finally brought out with a flourish his *Elixir Glycyrrhiæ Comp.*, with the assurance that it would completely cover the taste of quinine. In response to a question, however, he confessed that it would only disguise the taste for a few hours, "but there are none of these preparations that will cover it for any length of time." At this stage I picked up a sample vial of Burroughs' extract, with the remark that I had found that preparation very satisfactory. The agent tasted the sample with a very deprecatory air; "Yes, that tastes very well, but isn't there sugar in it?" "Yes," I replied, "there is simple syrup in it, and *eight grains of quinine, which has been there for three weeks.*"

For once the cheek of an agent failed, and with a hasty "good morning," he withdrew.

SELECTIONS.

MEDICINE.

THE USE OF TOBACCO BY BOYS.—The use of tobacco by growing boys is so generally recognized as pernicious, that it is extraordinary that more energetic measures are not urged upon those having the care of youth to prevent the habit. Already it has been prohibited in the U. S. Naval Academy, at Annapolis, in the U. S. Military Academy, at West Point, in the Phillips Exeter Academy, New Hampshire, and in various other enlightened educational institutions.

This was not the result of prejudice or hobbyism. If any set of men are free from these vices of learning, it is the naval surgeons, and it was especially from them, and particularly from Dr. A. L. Gihon, U. S. N., that this attack on the weed began. The indictment laid against it charged:—

1. That it leads to impaired nutrition of the nerve centres.
2. That it is a fertile cause of neuralgia, vertigo and indigestion.
3. That it irritates the mouth and throat, and thus destroys the purity of the voice.
4. That, by excitation of the optic nerve, it produces amaurosis and other defects of vision.
5. That it causes a tremulous hand and an intermittent pulse.
6. That one of its conspicuous effects is to develop irritability of the heart.
7. That it retards the cell change on which the development of the adolescent depends.

This is a formidable bill of particulars, and yet each of these charges is preferred by the best modern authority, and what is more, each is substantiated by an abundance of clinical evidence.

Testimony is also adduced from the class records of schools and colleges, which indicate very positively that the effect of tobacco on the mental faculties is deteriorating. The best scholars are not tobacco users; non-smokers take the highest rank in every grade; and whether we look at the exceptionally brilliant students, or compare the average of those who use and those who refrain from using tobacco, the result shows the same.

With these facts staring us in the face, it becomes the duty of every

schoolmaster and every parent to set himself resolutely against the beginning of this injurious indulgence.

It is, indeed, no easy matter to prohibit it successfully. There is a curious attraction about this nauseous plant, which has never been explained. An habitual consumer of it cannot explain its fascination. It has extended over the world with marvelous facility.

Nevertheless, we believe that the youth of America are intelligent and ambitious enough, in the aggregate, to be trusted. If the consequences of tobacco using are plainly stated by an authority that a lad respects, it will often lead him to drop the habit, or to refrain from beginning it, when threats and punishments would not. The latter he regards as an exercise of arbitrary power, the former appeals to his reason and good sense. It is the duty of a physician to express himself plainly on this subject, and he can only do so by condemning the habit in boys at any rate.—*Med. and Surg. Reporter.*

GUAIAC, FOR THE CUTTING SHORT OF ACUTE TONSILLITIS.—Dr. Morrell Mckenzie says that guaiac given early will rarely fail to cut short an acute tonsillitis. The formula is as follows:

R. Resin guaiac.....℥ij.
Gum tragacanth.....℥j.
Sacchar. alb.....℥ss.
Black currant paste.....q. s.

M. Divide into 350 troches. Sig.: One every two hours.

One can also give aconite, as recommended by Ringer. If the disease is not checked, give small pellets of ice.

INCONTINENCE OF URINE.—For incontinence of urine in children, Dr. Janeway (*Medical Record*,) recommends a combination of ergot, belladonna and iodide of iron.

R. Tinct. Ergot.....2 drachms.
Tinct. Belladon.....1 drachm.
Syr. iodide iron.....1 ounce.
Simple elixir.....1 ounce.

M. One teaspoonful morning, noon and bedtime to a child ten years old.

BURNT ALUM IN AGUE.—Baboo Brojendra Nath Banerjee states that this is a very cheap, easily procurable, and efficient antiperiodic medicine. The value of alum is chiefly marked in cases of fever in which the at-

tacks come on with clock-work regularity; It generally fails in irregular types of intermittent fever. Two doses are generally sufficient to complete the cure. Eight grains of burnt alum are to be given in each dose. The first dose is to be given three hours and the next an hour before the expected attack of fever.—*Indian Med. Gazette.*

COMA IN INEBRIETY.—*Coma*, from excess of alcohol, is often very difficult to distinguish from other forms of unconsciousness. Many grave blunders have been made by men distinguished for accurate diagnosis. The odor of spirits is a valuable aid, but not to be exclusively depended upon in the diagnosis. The absence of paralysis, the presence of a complete muscular relaxation and anesthesia, and the lowered pulse and respiration, are all very significant signs. A low temperature, which, according to the best authorities, ranges in the latitude of five degrees below the normal standard, is not absolutely peculiar to this state, but, as a rule, either points to this condition, or that of uremic poisoning.

The pupils are invariably contracted, but readily dilate, from any stimulus, external or internal. This is thought to be more nearly a pathognomonic sign of the alcoholic coma. This dilation of the pupils readily contracts, more positively as unconsciousness deepens. Excepting this alternation of pupils, no other sign can be said to be reliable. It is obvious that all cases of unconsciousness, without any history, should receive the most careful study before any diagnosis can be made.—*Qr. Jour. of Inebriety.*

A HINT FOR THE TREATMENT OF PHTHISIS.—Mr. H. Osborn Bayfield suggests (*British Medical Journal*) that the use of inhalations of volatilized palm oil may be useful in the treatment of phthisis. He bases his opinion upon the fact that workmen engaged in tinning where palm oil is used as a flux inhale the volatilized oil and get fat. Those previously emaciated or weak rapidly improve. The idea is worth a trial.—*Med. Record.*

NIGHT SWEATS OF PHTHISIS.—Da Costa considers ergotin the best remedy for the night sweats of phthisis—two grains three or four times a day. It is less prompt than atropia, but it is free from unpleasant effects.—*Maryland Med. Journal.*

PRESCRIPTION DANGERS.—In the paper (printed in this issue*) read by C. M. Miller, Mansfield, O., before the Ohio Pharmaceutical Association, is given an instance of the risk which physicians frequently cause to both their patient and the dispensing pharmacist by their neglect to give explicit directions *on the prescription* for its administration.

The writer recalls similar experiences where "first-class funerals" were only avoided by the apparent impudence of the pharmacist inquiring how the prescription was to be used, and taking the responsibility of writing such directions on the label, although the prescription originally had nothing of the kind, only "use as directed," or in many cases, not even that much.

What should the pharmacist do with the following prescriptions?

R. Tinct. Rad. Aconiti, ... ℥ iv.

S. Use as directed.

R. Liq. Plumbi Subacetat. ℥ iv.

S. Use as directed.

R. Morphizæ sulphas. gr. xxiv.

Aquæ ℥ iij. Ft. solutio.

S. Use as directed.

In the first case the dispenser inquired how it was to be used, and was informed that three drops was to be the dose in a teaspoonful of water. Knowing the physician, he ventured to give four drachms in a one ounce vial, labeled it with a red strip, "The Drops," and wrote the directions in full on the label. He then saw the physician, asked him how much aconite he had prescribed for Mrs. —, and was told "One ounce." When shown the prescription, the physician could hardly comprehend how he had made "four" ounces when he had but "one" on his mind. Had the directions *in full* been on the label, his thoughtlessness would not have been so risky as to place such a quantity of a dangerous remedy (poison) unlabeled in a household. In fact, it should never be sent out undiluted as a medicine to be administered in such a way.

The second example appears perfectly plain, and at the time of its dispensing caused no remark; it is no unusual prescription. Some few hours later, however, it was evident that some unexpected trouble was on hand. In this case, the "Use as directed," to the apothecary, had been to the family "Give the patient a tablespoonful," and a tablespoonful had been administered without any hesitation. Of course some unpleasant

*[And which we have also reprinted in this issue of the JOURNAL. J. F. B.]

symptoms arose; the physician was sent for; he pronounced it mysterious at first; the symptoms were somewhat alarming, and evidently arose from the administration of the remedy. The physician at once called at the store to inquire what had been dispensed, and was somewhat amazed when confronted with his prescription. He had meant it for "Liq. Ammon. Acetatis," but had made a mistake, and in his thoughtlessness directed a very different article. Had the directions for administration been placed *on the prescription*, instead of entrusted to the family or patient, the dispenser would never have sent it out without further inquiry.

The question might here arise, Why did he not label it "for external use?" But what warrant had he for it? And besides, it was not an infrequent prescription from that very physician, had been dispensed for him many times on just that same direction, and the dispenser was acting on a fair warrant of the physician's intent and meaning.

The third prescription certainly is plain enough to read; there is no doubt as to the article ordered, or the quantity, and its only fault as a prescription is that no directions are given for its administration. In this case an inquiry was (*apparently*) made casually as to the patient's illness (he was known to the pharmacist), and it was stated that the doctor said he had malaria. Of course the dispenser thought that morphia in one-grain doses would be heroic treatment for malaria which would soon stop the complaint of the patient, and he, stating that he would send it to the house shortly, called on the physician, who at once acknowledged that he had intended to write for *quinine*. The matter was soon adjusted, and now-a-days that physician *always* writes his *directions on the prescription* so that it may be put on the label.

Another case is called to my mind in which one-half grain morphine pills were ordered (six only). No directions were given, but the patient forgot the oral instructions of his physician and exceeded them, with a fatal result.

These are but a few of many similar examples of the experience of one pharmacist. Others could bring many more of their knowledge.

Physicians *should always* write their directions in full upon their prescriptions, so they should appear on the label; and, in addition to this, should designate the purpose or use of the remedy, as Drops; Mixture; Liniment; Eye-wash; For external use; Lotion; or some such general term, so that the pharmacist can affix such a special label on the container.—*Chemists and Druggists Bulletin*.

ACID PHOSPHATE IN INEBRIETY.—The use of phosphoric acid in inebriety is very general, and the results are, in most cases, eminently satisfactory. It seems to act as a nerve tonic and sedative of peculiar power, after the withdrawal of alcohol, and during the first stage of convalescence. For many years I have used the ordinary preparation of dilute phosphoric acid, with some bitter tonic, generally an infusion of gentian or cabumbo, getting excellent results within a limited period. But occasional uncertainty and limited duration of its action has been a source of annoyance that could not be explained. For instance, in one case after a few days' use, an intense irritation of the stomach and indigestion would follow, the system apparently only tolerating small doses at intervals of days. In other cases this remedy was followed by rapid restoration and signal good results up to a certain unknown point, then revulsion would take place. After an interval of rest the same marked results would appear for an equally uncertain time. No change of formula ordered had any influence over the uncertain action in some cases. Within a year I have used the acid phosphate by Horsford, of Providence; a preparation composed of phosphoric acid, with the phosphates of lime, magnesia and potash. In the experience so far, in the same cases in which the ordinary form of phosphoric acid was used, none of the unpleasant effects mentioned above have been noticed. The sedative effects seemed quite prominent, in many cases lessening nerve irritation and the general insomnia, which is so common in these cases. Two facts are clear from my experience, viz.: that it is more positively a brain and nerve tonic for the disorders of inebriety, and that the system will tolerate its use longer with more permanent good results. In many cases of insomnia its action has been prompt and very marked, producing sleep equal to chloral or the bromides. This remedy should receive careful study by all who are treating inebriety; at present, it gives promise of being almost a specific. Hence it should be tested clinically and its real value determined. This subject will be referred to again in the future issues of this journal.—T. D. Crothers, M. D., Editor of *Quarterly Journal of Inebriety*.

PARVULES.—(By Joshua A. Stites, M. D., Physician and Surgeon to Nye County Hospital and Prison, Belmont, Nevada.) Parvules are minute pills, and are offered to the profession in various forms, such as acid arsenious, 1-100; acid salicylic, 1-10; aconite rad., 1-20; aloin, 1-10; arsenic iodid, 1-100; belladonna fol., 1-20; calomel, 1-20; Dover's,

1-3; ergotin, 1-10; ferrum red., 1-10; iodoform, 1-10; morphia, 1-50; nux vomica, 1-50; opium, 1-40; phosphorus, 1-200; strychnia, 1-100, etc. As prepared by Messrs. William R. Warner & Co., of Philadelphia, they are saving to the busy practitioner, relieving him of the trouble of writing a prescription and preparing the medicines for the administration in cases requiring prompt treatment, while the medicines can be entirely relied on for purity and accuracy. The doses are so arranged that the youngest infant can take them. The parents are pleased with the avoidance of all struggling and resistance from the child, who has come to have a horror of the spoon, while this form of dosage is pleasing and tempting. In treating constipation, skin eruptions, etc., where medicine must be given for a long time, nauseating doses are frequently rejected by the little ones.

In females, where constipation exists, I give aloin, calomel and podophyllin, three each, for a cathartic, three or four times a day, which relieves chronic constipation after taken for a short time. The above firm also get up a convenient pocket case for practitioners, containing from ten to twenty varieties of drugs, which is just the thing for a physician in city practice who is thus saved writing a prescription and waiting for it to be filled. The cases are neat, compact and serviceable. In my practice here I am often called up at night, and while the messenger gets my horse and buggy ready I put together my case of parvules and what other things I may need, and am ready to start. It is at these times I find the parvules so useful, handy and reliable, as it is almost impossible to carry liquid drugs, tinctures, fluid extracts, etc.—*Med. Summary.*

PREPARATIONS OF ACONITE.—Dr. Squibb, in his *Ephemeris*, writes concerning the value of the different preparations of aconite and its alkaloid. He concludes that the fluid extract of the root is the best preparation for internal use. The dose is one minim, which may be given every three hours, or oftener if needed. For external use, he says, there is no form better or more convenient than an oleate of aconitia, made by dissolving two grains in 98 grains of oleic acid. A fluid ounce of oleic acid, weighing 412 grains, requires 8.25 grains of aconitia to make a 2 per cent. solution. Each minim of this oleate contains about 1-60 of a grain, and this quantity applied locally and repeated according to circumstances, should be an efficient dosage, and should in a short time produce constitutional effects by its absorption. It should be applied to the surface by the cork of the vial, or by some non-absorbent, without

I.—6.—4.

friction, and about the head and face it needs no covering; great care must be taken that it does not get into the eye. In using it around the eyes this caution must never be forgotten. If applied under the clothing it should be covered with oiled silk or rubber tissue. Local neuralgias are much better reached by the dermic or epidermic method of treatment.—*Med. Record.*

ERGOT IN WHOOPING COUGH.—Dr. Dewar, after a very extensive trial, places Ergot at the head of the remedies for Whooping Cough. Before beginning the use of ergot he regarded the combination of bromide of potassium and tincture of belladonna, or sulphate of zinc and tincture of belladonna, as the best remedies. In Dr. Dewar's experience ergot seldom fails to cure whooping cough in from one to three weeks—the cases that are longer in getting better are those complicated with bronchitis, or with troublesome bronchial catarrh. He gives from four to fifteen minims of the liquid extract every three or four hours to children of three months and upwards. The benefit of the secale is at once apparent, the fits of coughing occur less frequently, and are not so severe when they do occur. When the child is much debilitated he combines it with other remedies, especially the compound syrup of phosphates.—*The Practitioner.*

AQUA CHLOROFORMI:—This is made by shaking chloroform in a bottle of distilled water, allowing the excess of chloroform to settle to the bottom, and then decanting or syphoning off the supernatant water, which is a saturated solution of chloroform. This should be diluted for administration. It is said to furnish a pleasant vehicle for many unpleasant medicines, such as castor oil, etc. It is also considered valuable in allaying the various disturbances which occur during digestion, such as a feeling of distention, eructations, etc. It is recommended highly for the dyspeptic troubles, associated with dilatation of the stomach.

GONORRHEA:—An anonymous M. R. C. S. in the *London Lancet* gives the following treatment for gonorrhea, basing the same on his *personal* experience: Put one pound of roughly ground cubebs into a 200 oz. or wide mouth bottle of commerce; to this add 2 oz. iodide of potash; fill up the bottle with cold water, into the mouth of which drop several large lumps of camphor, simply to make it keep. Shake up two or three times a day for a few days, of course keeping it in a very cool place, afterwards pouring off the clear infusion, which is to be administered in regular consecutive doses.

COLUMBUS MEDICAL JOURNAL.

SELECTIONS.

SURGERY.



TO PHYSICIANS.

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RUMFORD CHEMICAL WORKS,

PROVIDENCE, R. I.

SURGERY.

ESMARCH ON THE TREATMENT OF INJURIES OF THE BLOOD-VESSELS IN WAR.—The following is the substance of a paper read before the section of Military Surgery in the International Medical Congress held in London in August, 1881:

1. The indications for the treatment of injuries to the larger vessels, and for traumatic hemorrhage, have been materially simplified by antiseptics and artificial bloodlessness.

2. Ligature of the trunk of the artery above the wound, formerly practiced, is uncertain, and therefore should be abandoned, especially when the tissues are infiltrated by inflammatory exudation.

3. Styptics should also be abandoned, since they are uncertain in their action, and, by rendering the wound dirty, retard its union.

4. In every case of hemorrhage threatening life the injured vessel must, if possible, be laid bare at the injured spot and tied above and below with catgut or antiseptic silk.

5. The operation must be conducted strictly antiseptically and, in the case of the extremities, by the aid of artificial bloodlessness (Esmarch's bandage).

6. The chief means of making such operations easy lies in making a long incision, which lengthens the wound in the long axis of the limb. When life is concerned, it matters little whether the incision be an inch or a foot long; as, if it succeed in checking hemorrhage, and be conducted thoroughly antiseptically, a long incision heals just as well as a short one.

7. A proper incision having been made through the skin, the deeper tissues are laid open, the left forefinger being used as a director, upon which they are divided to the same extent by a blunt-pointed bistory. They are then held apart by either blunt or pointed hooks.

8. Coagulated blood is now quickly and energetically removed, either with fingers, sponges, or raspatories, and as thoroughly as if it were intended to make an elaborate dissection. The coagulated blood covers everything, and is a fertile soil for the noxious matters exciting inflammation.

9. This being accomplished, the vessels and nerves are felt for with the finger, and an endeavor is made to get some idea as to the nature of the injury by the aid of the cleansing sponge, with which arteries, veins and nerves are isolated.

10. If the veins be quite bloodless and collapsed, it is difficult to dis-

tinguish them from cords of connective tissue; it is therefore advisable to form a reservoir of blood below the wound by placing a ligature round the hand, for example, before applying the elastic bandage to the arm. Afterwards, on elevating the limb and removing the ligature, the blood flows out of the injured vein, if the vessel have been such.

11. If the injured part of artery or vein have been found and exposed sufficiently to enable the whole extent to be seen, the vessel must be isolated and tied, above and below the injury, in a healthy situation, securely and tightly, with catgut or antiseptic silk (reef knot). The vessel, if not already divided by the injury, is then cut between the ligatures. If any branches be found between the ligatures, they are isolated and tied, and separated from the trunk of the vessel.

12. The tubing is now released, and all remaining vessels from which any blood issues are ligatured; the limb being elevated, as in amputations when the tubing has been removed, to lessen the parenchymatous bleeding.

13. Divided nerves and tendons, should they be found in the wound, are to be united by fine sutures of carbolized silk or catgut.

14. Foreign bodies, *e. g.*, bullets, fragments of clothing, very loose bone splinters, should be carefully removed.

15. The whole wound is then disinfected most carefully by washing, rubbing and rinsing with solutions of chloride of zinc and carbolic acid, or iodoform spray. An endeavor must be made to penetrate into every crevice of the wound.

16. Counter-openings having been made in suitable situations, and drainage tubes introduced, the wound is closed by antiseptic dressing.

17. The performance of this operation is not suitable to the battlefield, because it requires much calmness, time and care; and because the antiseptic precautions can only be observed in a well-constructed lazarette.

18. For provisional hemostasis on the battlefield, elastic compression is alone suitable.

19. The use of styptics is to be forbidden, therefore such articles as perchloride of iron, etc., should be left out of the dressing materials.

20. Equally injurious and dangerous are the much used tourniquets, not only because they require a certain amount of anatomical knowledge in their application, but because the pad (be it ever so well adjusted) becomes displaced during transport, and so only checks the venous circulation instead of the arterial; the result being dangerous infiltration if the opening of the wound be closed, and recurrence of hemorrhage if it be open.

21. Satisfactory and lasting compression of the vessels is obtainable by an elastic tube or girth being drawn around the limb several times, tightly stretched. By this means the soft parts are so well drawn together, that not a drop of blood can pass through the vessels.

22. No anatomical knowledge is requisite, as the compression* is useful wherever undertaken. Displacement of the tube or girth is impossible in transport if the ends have been well secured.

23. Tourniquets should therefore be replaced by elastic girths in the stores and in the dressing-bags of the men of the hospital corps.

24. Since caoutchouc suffers by being stored, and loses its elasticity, it is impossible to keep a store of these girths in the magazines; and, in the event of war, contracts would be badly carried out.

25. I have, therefore, given a necessary article of clothing the construction necessary for its double use as a brace and as an elastic tourniquet.

26. This tourniquet-brace consists of an India-rubber girth, two feet long, and strong enough to compress every vessel in a limb at any point.

27. Since every soldier must have a pair of braces, and this one is not dearer than any other, the desire that each soldier should be so equipped in war is a reasonable one.

28. In this case, every soldier would carry a means of checking a dangerous hemorrhage in himself and others, on his own person. In case of a severe injury he would, in any case, not require braces; and on the field of battle the braces of the dead and wounded could be removed in great numbers if necessary.

29. These braces might also be used for tying-off poisoned wounds, for procuring artificial bloodlessness in operations, and for the resuscitation of the apparently dead after severe losses of blood, etc.

30. It is a matter of course that every wounded man, in whom hemorrhage has been provisionally checked by the girth, should be brought to a lazarette as soon as possible, in order that the compression may be there removed, and the definite ligature of the bleeding vessel carried out.

31. It is also of importance that, before applying the elastic tourniquet, the limb be bandaged in an elevated position; and, if the bone be shattered, that these should be rendered immovable during transport, by means of splints, etc.—*Lond. Med. Record.*

THE BEST CURE OF HIP-JOINT DISEASE.—Dr. O. H. Allis, of Philadelphia, makes some practical remarks on this subject in the *Medical Times*: An eminent surgeon has said that nine-tenths of the cases can be perfectly cured if taken in time. Granting this to be true, it is clinical experience that nine-tenths of the cases are not brought to us in the early stage. He divides every grade of the disease under two heads. In the first, or milder form, the manifestations are not such as to occasion alarm on the part of the patient or friends. There is slight lameness present, and active sports, exercise, and vocation are precluded; finally, after months, the patient seeming to get neither better nor worse, the hip presents every evidence of recovery from hip-joint disease, but with *fixation of the joint*. In the second, or severer type, he includes all cases coming under observation with unmistakable evidence of high destructive inflammation. The disease requires the most judicious surgical care to arrest it. Slowly but steadily the symptoms subside, health returns, and every evidence of local disturbance disappears, when an examination of the joint shows *fixation*. Fixation he believes to be Nature's best cure, and the question he asks is: "*Can cases that have passed through the inflammatory stage of hip disease, in which the disease has been arrested and a cure established through fixation, be further redeemed, and a movable joint established?*" Clinical teaching answers in the affirmative. His own experience is in the negative. He reports three cases in which he attempted to redeem the hip when Nature had cured by fixation; two resulted in death, and the third patient escaped, but not until he had been dragged to the verge of the grave by established surgical practice.

In the discussion that followed the reading of this paper, Dr. Barton entirely endorsed the position taken by the writer, and Dr. Willard reported three cases in which violent and destructive inflammation had been awakened in long quiescent joints—in one case by an accident, in another by excessive dancing, in another by the surgeon's manipulation. Should the ankylosed position be one unfavorable for locomotion, he would practice osteotomy rather than run the risk of exciting destructive inflammation in a region where the tissues were unhealthy, and where there was really no sound joint structure remaining.—*N. Y. Med. Jour.*

HEMATURIA—PEPSIN INJECTIONS.—Dr. Hollman (*Nederland Weekblatt*) used an aqueous solution of sixteen grains of pepsin as an injection into the bladder of a patient who had hematuria, and in whom a catheter failed to empty the bladder. After a few hours a dark, viscid, fetid fluid readily passed through the catheter.

RECTAL CONSTIPATION:—Dr. Benj. Lee, of Philadelphia, makes two suggestions (*Med. Bulletin*) for the mechanical relief of this form of constipation. The first consists in applying pressure with the ends of the fingers, protected if desirable by a soft cloth, against the most prominent point of the prolapsed mass, through the rectal wall, outside of the external sphincter, to convert the concavity of the pouch into an inclined plane, over which a comparatively slight expulsive effort will cause the mass to glide, especially if the inner walls of the anus have been anointed with some bland ointment. The point at which pressure usually proves most effective is just to the left of the sphincter posteriorly; but the finger passed rapidly around will readily place itself where it will do the most good. Patients should be taught to use this simple manipulation when they became conscious of the presence of an accumulation in the bowel which they cannot extrude.

The second suggestion relates to the shape of the opening in the water-closet seat. The hole of an ordinary seat is circular or oval in shape, and so wide as to admit a considerable portion of the fundament. As the body settles down the fleshy masses of the buttocks are forced together, thus crowding the anus and effectually preventing the opening of the sphincters. The softer and fatter the gluteal regions the greater will be the impediment thus produced, and hence the female will be the more seriously affected. The remedy is to change the shape of the opening, by making its width not to exceed about one-third of the one in ordinary use. The upper edge should be slightly rounded off—not beveled. Seated firmly upon such a support, the *nates* are pushed apart rather than forced together, so that an impulse to evacuate will be noticeably excited, and the evacuation will be comparatively easy, requiring but little action of the diaphragm and abdominal muscles.

A SEVERE OPERATION.—At the Surgical Section of the Association of German Naturalists and Physicians, Prof. König showed a patient in whom he had removed the greater portion of the sternum, which was the seat of a rapidly growing osteo-sarcoma. The whole of the sternum, except the uppermost part and the xiphoid process, was removed, and during the operation air entered both pleural cavities, and also the pericardium, which was found adherent to the sternum, and was opened during the operation. The patient made a good recovery, and the wound is now almost entirely healed, except at one point, where a portion of an adjacent rib is necrotic and keeps up some little suppuration.—*Med. Record*

I.—6.—5.

INTUSSUSCEPTION IN INFANTS.—Dr. W. R. Gillette (N. Y. *Med. Jour.*) states that he has succeeded in reducing three cases of intussusception in infants by the administration of chloroform, injections of warm water, and the application of massage to the mass felt through the abdominal walls. He knows of two other cases, where all the ordinary means failed, and reduction was effected by chloroform and massage. The children, in all these cases, were held, and the injections forced into them against all voluntary and involuntary efforts that they could make. In one case, the gut had been invaginated forty hours, and in another for three days. In one case, the particulars of which are recorded, the water, after three or four bulbfuls were thrown in, was rejected. This was repeated constantly; it seemed almost impossible to get the gut to retain any water. Finally, an assistant resorted to massage (the infant being under chloroform). Immediately there was a roar of rushing wind and water, and a large amount of water passed in and was retained. The child was laid down, warm bottles put around it, to rally it after the ordeal; the bowels were moved in a short time and a rapid recovery ensued.—*Med. and Surg. Reporter.*

HANDY INHALER FOR CHLOROFORM.—Dr. J. P. Thomas, of Kentucky, (*Louisville Med. News*), speaks highly of the use of an ordinary goblet as an inhaler. A handkerchief is stuffed into the bottom, upon which is poured the chloroform. The patient applies this novel apparatus to the face, and inhales the vapor until, as insensibility comes on, the hands and goblet fall to the side. He recommends this method specially in confinements, and where no assistant is at hand. He sums up its advantages as follows:

1. It is always at hand and can be had in any household.
2. It prevents waste of the anesthetic.
3. It permits at all times, without special attention of the physician, sufficient atmosphere to intermix with the anesthetic.
4. On account of the peculiar manner in which the goblet *does not fit* the mouth and nose, there is no necessity for intermitting the application.

A combination of ergot, belladonna and iodide iron is used at Bellevue Hospital, for incontinence of urine, and proves more useful than either of the drugs alone, or in any other combination which has been tried.

OBSTETRICS.

EXTRACTION OF TEETH OF PREGNANT WOMEN.—Among other casual communications, Mr. Henry Sewell brought forward a question as to the advisability of extracting the teeth of pregnant women. Such patients were constantly applying for relief, but when extraction was proposed—it being evident that the tooth was past saving—one was met with the answer that the patient's doctor did not consider that it would be safe for her to undergo the operation; so the patient continued to suffer, and her strength was reduced by the pain. His own opinion was that this was a sort of prejudice very much on a par with the idea that it was dangerous or wrong to extract a tooth during the acute stage of alveolar abscess; his practice was, during the early stages of pregnancy, to give gas and extract the tooth. In more advanced cases one must be guided somewhat by circumstances, but in even most of these he believed that extraction did no harm. Even if the patient was weak and nervous, the slight shock of the operation did less harm than the exhaustion produced by long-continued pain.

Messrs. F. Canton and A. Coleman said they were frequently asked this question, and never hesitated to answer it in the affirmative. They preferred to give gas in such cases, and took care to give it thoroughly. They had never seen any harm result from the extraction of teeth under these circumstances.

Mr. George Walliss said he never hesitated to operate when an operation was necessary. It happened on one occasion, in the case of a lady who was very near her time, that the child was born within twelve hours after the extraction; but she had been in great pain previous to the operation, and she had a much easier labor than she would have had with an aching tooth to add to her other troubles.—Report of Odontological Society of Great Britain, *Med. Times and Gazette*.—*Indep. Practitioner*.

A NEW SIGN OF PREGNANCY.—In the first two months of pregnancy there exists no sign which can be called diagnostic; Jorissenne (*Arch. de Tocologie*, June, 1882) seems to furnish one. Long ago Graves formulated the law 'that in cardiac hypertrophy the radial pulsations remain constant, whatever the position of the body. Starting with the assumption that in pregnancy there exists an hypertrophy of the heart (and this assumption, if erroneous, will not affect J.'s results), he has found that, whilst in health there is a variation of from ten to twenty beats in the

radial pulsation, according as the body is upright or horizontal, in pregnancy, no matter what the position, the beats number^rthe same. J. has been able to diagnosticate pregnancy as early as the first month when no other sign except the missing of a menstrual period was present. When examining a patient for this sign, it is necessary to proceed with deliberation, first counting the radial for the space of fifteen seconds whilst^rthe patient is standing, then sitting, and then reclining. The order may then be reversed, and uniformly the same number of beats will be recorded. J. promises an explanation of this phenomenon in a future paper.—*Amer. Jour. Obstet.—Med. News.*

THE most successful results ever attained in the Maternite Hospital in Paris (a mortality of only three-quarters of one per cent.) have been reached in the new pavilion, of which M. Tarnier says :

Each patient there has a separate room, entered^rfrom without, so that a nurse can only pass from one to another by going outside into the open air. The furniture is japanned iron; the floors, walls, and ceilings are of impermeable concrete. The mattresses and pillows are stuffed^rwith cut chaff, which is burnt after use in every single case. For the McIntosh sheet is substited one of brown paper, made impermeable by pitch; this is burnt after use. For the washing of the genitals weak solutions of bichloride of mercury are employed, as being the best and most powerful germicide.

The same enthusiastic accoucheur has invented a sort of incubator in which babies of an age heretofore considered non-viable are placed. This machine consists of two compartments, the lower containing hot water to furnish the heat, and the upper for the reception of the child, where he is enveloped in cotton and under a glass cover. The results are said to be very encouraging.—*Boston M. & S. Jour.*

PROLONGED GESTATION.—Dr. Lewis A. Rodenstein (*N. Y. Med. Jour.*) reports four well established cases of prolonged gestation. In the first case, gestation occupied a whole year; in the second case, three hundred and twenty-one days; in the third case, three hundred and thirty-five days; in the fourth case, three hundred and fifty days. These cases tend very strongly to support the justice of the French law, that the legitimacy of a child born three hundred days after the death or departure of the husband cannot be questioned.—*Chicago Med. Rev.*

VIBURNUM PRUNIFOLIUM.—Dr. O. E. Herrick, in commenting upon the occasional toxic effects of viburnum prunifolium (dryness of mouth, dimness of vision, dizziness, etc.), says: “Next to ergot I place more dependence upon viburnum in the treatment of diseases of females, than any other agent for internal administration. Its action is not limited to the prevention of miscarriage by any means, but it is alike applicable in cases of uterine engorgement, ovarian irritation, and numerous other conditions of the female sexual organs.”—*Obstetric Gazette*.

NON-ANTISEPTIC OVARIOTOMY.—Lawson Tait reports (*Boston Med. Jour.*, Oct. 28, '82,) one hundred consecutive ovariotomies, done “without any of the Listerian details,” and with only three deaths, one of which was accidental. Twenty-seven of the operations were double, and all successful. Six patients were pregnant, all recovered, and only one failed to carry the child to full term.

MEIGS' FOOD FOR INFANTS.—Dr. Arthur V. Meigs, son of J. Forsyth Meigs, and grandson of the great obstetrician, recommends the following as synthetically a perfect food for infants (*Phil. Med. News*):

Dissolve $17\frac{3}{4}$ drachms of sugar of milk in a pint of water; three table-spoonfuls of this solution, combined with two of lime water, two of cream, and one of milk, will constitute enough for an ordinary feeding. It should be warmed, and what is not needed should be thrown away, so that fresh may be prepared at each meal.

LUBRICANT FOR PESSARIES.—Make a solution of one drachm each of castile soap and salicylic acid in two ounces of water. This will also prevent all disagreeable odor from the rubber. Grease of any sort should be avoided, as it destroys the rubber.

OVARIOTOMY IN AN INFANT.—Dr. Hingston, of Montreal, recently removed an ovarian tumor from a child two years old. The patient was doing well at last account.

Ergot has been used to check the excessive flow of milk. One of the best remedies to promote the flow of milk is said to be jaborandi, or its alkaloid, pilocarpine.

REVIEWS AND BOOK NOTICES.

Prices are always inserted when furnished by the publisher, or when obtainable from the bookseller.

A Practical Laboratory Course in Medical Chemistry. By John C. Draper, M. D., L. L. D., Prof. of Chemistry in the Med. Dept. Un. of N. Y., etc. New York. Wm. Wood & Co. 1882. Pp. 72.

This is a most admirable little book for the use of the laboratory student. It is bound so as to open from the top, so as to easily lie open on the table, and, as it lies open, the lower page has been left blank for any notes and additions which the student desires to make as he proceeds with his work.

It cannot but prove satisfactory as a chemical *vade mecum*.

The Diseases of the Rectum, including Fistula, Hemorrhoids, Painful Ulcer, Strictures, Prolapsus, etc., with Diagnosis and Treatment; by William Allingham, M. D., F. R. C. S.: Fourth, revised and enlarged edition, with illustrations; P. Blackiston, Son & Co., Philadelphia. 1882. Pp. 168. Price: Paper, 75 cents; Cloth, \$1.25.

This is the title of a work, which, published in the English originally, has been translated into the French, Italian, Spanish and Russian languages. This alone is a sufficient commendation.

We have space to notice but two points: The author highly approves of the elastic ligature in operations for the cure of anal fistula, *in proper cases*; it must not be used indiscriminately. He does not regard the existence of phthisis as a contra indication of fistula operation, provided other circumstances make the operation desirable.

The style is fresh and agreeable, and eminently that of a man full of his subject.

The Change of Life, in Health and Disease. A Clinical Treatise on the Diseases of the Ganglionic Nervous system incidental to Women at the Decline of Life. By Edward John Tilt, M. D., Past President of the Obstetrical Society of London, etc. Fourth Edition. Philadelphia: P. Blackiston & Co. 1882. Octavo; pp. 184. Paper.

In his preface, Dr. Tilt indulges in some caustic strictures on the American tendency to push surgical operations on the uterus to excess, as Sims' "slitting of the womb," Emmet's "tracheloraphy," etc., and congratulates the "objects of his solicitude" that they have "reached that

most enviable time of life when the womb is well-nigh safe from the onslaught of American surgery, and the more vexatious, permanent irritation of pessaries that do not fulfill their object;" from which it may be inferred that there is not always harmony even among gynecologists.

Chapter I is introductory. Part I is on the Physiology of the Change of Life, and is included in Chapter II. Part II embraces the General Pathology of the Change of Life, and requires three chapters. Part IV treats of the Special Pathology of the Change of Life, and is contained in seven chapters.

The subject is fully, if not exhaustively, treated. The attributing of most functional affections of this period to disorders of the ganglionic nervous system is rather a hobby of the author, and will not receive universal assent. The author's style is lucid, and the whole work is interesting reading. Many valuable tables are interspersed. It is the only comprehensive work we have seen on this important topic, and we recommend its perusal.

G. A. C.

The Medical Record Visiting List, or Physicians Diary for 1883. New York: William Wood & Co.

This diary is made with especial reference to the daily needs of physicians, and is one of the handsomest works of the kind that we know of. Sixteen pages are devoted to tables and facts of various kinds, which every physician should have at hand for speedy reference. The usual columns, for daily memoranda of visits and other professional services, are followed by spaces intended for an entry of the amount to be charged, and the page in ledger on which it is posted, while wide space is left for clinical notes or special memoranda.

Is furnished either with or without dates at the same price. Price: 30 patients a week, \$1.25; 60 patients, \$1.50.

Laceration of the Female Perineum and Vesico-Vaginal Fistulae—Their History and Treatment. By D. Hayes Agnew, M. D., Professor of Surgery in the Medical Department, University of Pennsylvania, etc. With seventy-five Illustrations. Philadelphia: P. Blakiston, Son & Co. 1882. Price, paper, 75 cents; cloth, \$1.25.

This book is made up almost entirely from the author's unusually rich experience. From beginning to end it is full of valuable suggestions, and the author's plain but pointed style adds a positive charm. We know of no work, on these two subjects, so comprehensive, plain and practical as the one before us, a copy of which every operator should have and read carefully.

I.—6.—6.

Quiz Compend. Questions on Human Anatomy. By S. O. L. Potter, M. D., author of "An Index of Comparative Therapeutics," etc. 63 illustrations. Philadelphia: P. Blakiston, Son & Co. 1882. Columbus, A. H. Smythe & Co. 12 mo.; pp. 139. Price, cloth, \$1.

This book is one of a bad lot. We wish that all these short-cuts to anatomy—for that seems to be the favorite theme of these trashy "authors"—could be burned, and, for matter, if their originators could only be disposed of in the same summary way, the world would be the better for the purification.

This book possesses at least one merit; that it makes no pretense of virtue, but states plainly that it is intended for the use of the student "in preparing for final examination," that all "essential points" have been so arranged as to be acquired "in the shortest possible time," and that the matter has been "confined to those points which must be known *in order to pass.*" The words we have italicized are the key-note of this book, and of all similar publications.

There is a demand for these books, and this demand will be supplied, we suppose, until some medical Anthony Comstock rises up and secures their suppression, as opposed to decency and good order.

The Physician's Visiting List for 1883. Philadelphia: P. Blakiston, Son & Co.

For thirty-two years, this very useful book has made its annual appearance. Two sizes are made, for twenty-five and fifty patients, respectively. Besides the daily visiting list, there are an almanac, a description of Marshall Hall's ready method in asphyxia, tables of poisons and their antidotes, weights and measures—including the metric—a posological table, with blanks for the addresses of nurses, obstetric engagements, accounts, etc. We welcome its familiar face, and only suggest that the method of resuscitation adopted by the Michigan Board of Health is probably better than that of Hall, and should take the place of the latter.

Aids to Rational Therapeutics. By J. Milner Fothergill, M. D., M. R. C. P. New York: G. P. Putnam's Sons. 1882. 16 mo. Pp. 120. Paper, 25 cents; cloth, 50 cents.

This is one of the "Students' Aids Series," and is a capital little book, not only for students but for veterans as well, as it will serve to recall many a rusty point in therapeutics. The why and the wherefore, in prescription writing, are well explained, not only by precept but also by example, for there is scarcely a page that is not adorned by one or more prescriptions. It is just the book to carry to a tedious labor case.

The Pharmacopeia of the United States of America. Sixth Decennial Revision. By authority of the National Convention for revising the Pharmacopeia, held in Washington, 1880. New York: Wm. Wood & Co. Cloth. Pp. 488. Price, \$4. Columbus: A. H. Smythe & Co.

There has been a large amount of labor expended on this revision. The arrangement is strictly alphabetical. The crude drugs are carefully described, their dimensions and external characteristics being given, with odor, taste, etc. Common adulterations are also pointed out. The substitution of parts by weight for the previous weights and measures, is a measure of questionable utility—so far as the ordinary druggist is concerned.

Few changes have been made in the strength of any of the preparations, except those containing opium. Here, as pointed out by Dr. E. R. Squibb, in his *Ephemeris*, the quantity of morphia in the tincture, and deodorized tincture, has been increased by about 50 per cent.; so that a full dose of the laudanum of 1870 being 24 minims, or 38 drops, representing a quarter grain of sulphate of morphia, a full dose of the new laudanum, that of 1880, will be 16 minims, or 25 drops.

This is an important change, and until druggists have had time to work off their old stock, physicians should designate the old or the new strength, by adding (1870), or (1880), as they prefer.

Handbook of Ophthalmic Practice. By Charles Higgins, M. D., F. R. C. S., Asst. Surgeon in Ophthalmic Department, Guy's Hospital. Second edition, revised. Philadelphia: P. Blakiston, Son & Co. 1882. Columbus, George W. Gleason. 16 mo.; cloth; pp. 116; 50 cents.

This little work is admirably adapted for the use of students about to attend lectures on Ophthalmology, as it will give them a very fair general idea of the subject, such as will greatly aid them appreciating cases presented and topics discussed.

Walsh's Physicians' Combined Call-Book and Tablet. Second edition. Ralph Walsh, M. D., 332 C street, Washington, D. C. Price, \$1.50.

This is of a very convenient shape, being longer than the others in ordinary use. It accommodates 35 patients per week. The issue for 1883 contains a large amount of information. Among the tables are, one giving the number of drops of various liquids in a fluid drachm, one to regulate the dose of medicine to be given to children, abbreviations, poisons and their antidotes, a posological table, and all the usual variety of things worth knowing that are looked for in such a hand-book.

The North American Review for December commands attention no less by the eminence of its contributors than by the value and timeliness of its table of contents. First, there is a symposium on "The Health of American Women," regarded from three distinct points of view: Dr. Dio Lewis considers the question as it is affected by the prevailing style of feminine attire, especially by the practice of tight lacing; Mrs. Elizabeth Cady Stanton points out the many injurious influences of social environment; and Dr. Janes R. Chadwick sets forth the effects of education, climate and food, and finally discusses the question whether the modification produced in the European human type by transfer to American lessens the fertility of women. Gov. Buren R. Sherman, of Iowa, writes of the "Constitutional Prohibition" of the liquor traffic in that State, and maintains that the measure is in entire accord with the traditions of the original settlers, and approved by men of all political parties and nationalities. General Grant, in an article entitled "An Undeserved Stigma," states the facts of Gen. Fitz John Porter's case, and argues that the sentence of the court martial that cashiered him was based on a misconception of the essential circumstances. Richard A. Proctor writes of "The Influence of Food on Civilization," discussing with much learning and force some of the most interesting sociological problems of the present day of the near future. Prof. Fisher, of Yale College, in defining the causes of "The Decline of Clerical Authority," holds that this decline, which affects the status of church and minister only as a part or function of the secular State, is by no means to be regretted, and that the spiritual influence of the church and its ministry is to-day greater than of old. Finally, there is a symposium upon the conditions of "Success on the Stage," the contributors being six of our most prominent actors—John McCullough, Joseph Jefferson, Madame Modjeska, Lawrence Barrett, Maggie Mitchel, and William Warren.

The Popular Science Monthly. Volume XXII. This magazine draws from the intellectual resources of all nations, and is now recognized as the most successful scientific periodical in the world.

Appealing to no one class, it is patronized by intelligent readers of every class all over the country. It is widely taken by the cultivators of science in all branches, and by physicians, engineers, scientific farmers, and those pursuing the mechanical and manufacturing arts. Thoughtful clergymen find it indispensable, and are extensively enumerated among

its subscribers. Teachers, finding its discussions of the scientific principles of education invaluable, are among its most liberal supporters. It has a large clientage among the lawyers, and it is not easy to find an honest and independent student of politics that does not read it.

The reason of this is, that our best minds are getting tired of the shallow frivolities of sensational literature, and demand a magazine that elevates the standard of popular reading in this country. Science is the great agency of improvement in this age, private and public, individual, social, professional, and industrial. In its irresistible progress it touches everywhere, and affects everybody. It gives law to the material interests of the community, and modifies its ideas, opinions, and beliefs, so that all have an interest in being informed of its advancement. Those, therefore, who desire to know what is going on in the world of thought in these stirring times, when new knowledge is rapidly extending, and old errors are giving way, will find that they can only keep informed by subscribing for *The Popular Science Monthly*.

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HANN & ADAIR, Publishers, Columbus.

THE NEW HOSPITAL IN DAYTON.—The new St. Elizabeth Hospital, in Dayton, was dedicated to its charitable work with appropriate ceremonies, on Sunday, November 19. Until four years ago, Dayton was utterly destitute of any proper provision for the sick and injured poor, a disgrace which was keenly felt by the local medical profession, and it has only now acquired a hospital commensurate with the commercial and fi-

nancial standing of the city. The hospital was built by, and is under the exclusive control of the Order of the Sisters of the Poor, of St. Francis. Recognizing the necessity of more ample accommodations, the Sisters, about one year ago, began the construction of the present building. Unaided by the municipal authorities, or by any large benefactions, they have succeeded in erecting and furnishing a hospital building at a cost of about \$75,000. Exclusive of the basement, the main building is seven stories, and the wings are six stories in height. The entire structure has a frontage of one hundred and fifty-eight feet, and a depth of ninety feet, and has a capacity of two hundred beds. The first floor is devoted to administrative purposes, and the sixth and seventh floors are reserved for the use of the Sisters.

Instead of the customary large general wards, there are eight smaller ones, each measuring twenty-three by thirty-two feet; numerous rooms, with accommodations for from three to eight beds, and, in addition, many single and double rooms, suitably furnished for the use of pay patients.

The building throughout reflects all of the latest improvements and conveniences in hospital construction, and is admirably fitted for the work to which it is now formally dedicated.

Since the public opening, the dedication has been appropriately completed by a successful ovariectomy, under the care of Dr. Reeve. The medical interests of the new institution are, at present, looked after by the old staff, composed of the following gentlemen: President of Staff: J. C. Reeve, M. D.; Consulting Physicians and Surgeons: John Davis, M. D., T. L. Neal, M. D., E. Pilate, M. D., J. M. Weaver, M. D.; Visiting Surgeons: H. S. Jewett, M. D., J. D. Daugherty, M. D., W. J. Conklin, M. D.; Visiting Physicians: J. S. Beck, M. D., A. H. Idings, M. D., P. N. Adams, M. D. W. J. C.

MALARIA IN SKIN DISEASES—A CORRECTION.—Some time since the following paragraph appeared in the *Michigan Medical News*, and has been widely copied in the medical journals of the country:

A century ago John Hunter divided all skin diseases into three classes, one of which is cured by mercury and the iodides, a second by sulphur, and a third class which the devil himself can't cure. Dr. L. P. Yandell, who quotes Hunter as above, is given credit for a much less complex

classification than even this. He attributes all skin eruptions to malaria. Quinine is a specific for malaria; ergo, quinine is the remedy for all skin eruptions. Q. E. D.

We are in receipt of an advance slip from Dr. Yandell's journal—the *Louisville Medical News*—in which he protests against this misrepresentation, not only on his own account, but also in the interests of science. We have long known of Dr. Yandell's somewhat peculiar views, and we have long been convinced that if not entirely true there was much of truth in his doctrine.

Dr. Y. believes as follows: Malaria is the *chief source of acute skin disease*; scrofula is the *chief source of chronic skin disease*; and the more inveterate cases of skin disease are often due to the co-existence of these two things. The specific exanthems, of course, he does not include here, but even their progress and termination are often largely influenced by the presence of malaria, or struma. He does *not* claim that malaria and struma are the *sole* causes of the dermatoses. *Many* of the dermatoses may exist *independently* of malaria or struma, and most frequently some exciting cause is necessary to develop the cutaneous eruption. Among the exciting causes are irritants, injuries, insufficient or improper ingesta, vicissitudes of temperature, alcohol, dentition, menstruation, parturition, lactation, etc.

In proof of the truth of his views, he claims that, in the first place, the diseases of the skin are cured more certainly and more quickly by the antimalarial remedies on the one hand, and by the anti-strumous on the other, than they are by any other line of therapeutics; and, in the second place, careful and painstaking investigation will, in the majority of dermatoses make apparent the existence of the malaria or the struma, as the case may be.

Dr. Yandell is too broad in his views to confine his theory to skin diseases alone. What will produce disease in the skin, will produce it in any organ of the body. What is true of dermatology is equally true of gynecology and ophthalmology and otology, and it is just as true of the diseases of all the other regions of the body.

Dr. Y. announced these views several years ago, and he now says that subsequent observation has only confirmed them.

LIGATURE OF THE INNOMINATE.—William Thompson, M. D., M. R. C. S. I., reported the case at the last meeting of the British Medical Association. His case makes the fifteenth on record of ligation of this

great trunk for aneurism, or, including Smyth's case, in which the carotid was tied as well, the sixteenth. The operation of Smyth (of New Orleans, May 15th, 1864,) was the only successful one. Thompson's patient died on the 42d day, his survival being the longest on record, except Gaefe's case, where death occurred on the 67th day.

Notwithstanding the "terribly disheartening" mortality of the operation, Mr. Thompson is firmly persuaded of its propriety, and indeed, in reading his published account (*Brit. Med. Jour.*, Oct. 14, 1882), one can hardly help agreeing with him. Several of the deaths have been, like his, due to an accidental complication, rather than to the operation itself. In his case an ulcer formed, owing to the deeper parts of the wound not being held in apposition, on the distal side of the ligature. The ulcerative action extended through the walls of the vessel and along the clot in its interior, until it finally ate its way through the organized material at the site of the ligature, and fatal hemorrhage followed.

The ligature used was that introduced by Mr. Barwell, viz: the ox-aorta tape ligature, and answered the purpose most admirably.

PROFESSIONAL FEES AND SKILLED TREATMENT TO BE DETERMINED BY EXPERTS.—Judge Campbell, of the Supreme Court of Michigan, in the case of Wood v. Barker, has recently given a decision which is of interest to physicians, especially as establishing a valuable precedent. The case was one in which suit, brought for professional services, was met by the counter-claim of malpractice. The Judge ruled as follows: (Wood v. Barker, filed October 18, 1882, Supreme Court of the State of Michigan, Campbell, J.)

"There is no presumption of law as to the value of a surgeon's services, nor that a jury can ascertain their value without testimony from persons knowing something about it. Nor has the jury a right to reduce the compensation claimed for such service where undisputed testimony shows it to have been appropriate, and on their unsupported notions that the treatment adopted should have been different.

"A jury has no right to ignore testimony that has not been discredited, and form independent conclusions, without testimony, on matters that require proof beyond their conjectures or opinions.

"The fact that a surgeon changes a course of treatment adopted by another, does not in itself show that the former course of treatment was not proper at the time; nor is the patient's failure to recover perfect soundness of limb in itself evidence of malpractice, nor is the fact that he survived, although he refused to allow a particular course of treatment,

evidence that such course might not have been proper under the circumstances.

"The jury in an action for the value of surgical services has no right to find malpractice without testimony from persons who are qualified to give opinions on the method of treatment."

AN INTERESTING RELIC.—The following bill, in the possession of a gentleman of this city, shows that while physicians' charges were formerly much less than at present, their accounts were fully as hard to collect:

"WESTFIELD, Jan. 28, 1823.

"Mrs. Farmer:

"Since the time of our last settlement, October 15, 1823, I have had charges against you to the following amount:

1825—To a visit and opening your face.....	\$o 33
February 19, 1826—To calling, advice, etc.....	17
September 5, 1826—To physic.....	o8
To laudanum.....	o8
	\$o 66

"Also, I find the following still older account:

March 12, 1812—To a visit and mineral wash for Maria....	\$o 33
Nov. 12, 1810—To sal. succini and seneca.....	20
Dec. 22, 1855—To a visit, etc.....	33
To ½ dozen pills.....	o8
	\$o 94

"Neither of these very small bills have been paid. I am confined to my house by sickness, and every little assistance of this kind does me some good.

Yours Respectfully,

"WILLIAM ATWATER."

The Doctor's appeal, however, did no good; his account was not paid; for four years later the following significant entry appears on the bill:

"Received the above in full of Mrs. Farmer, April 5, 1837.

"JAMES FOWLER,
Executor."

"\$1.60.

JOURNAL OF CUTANEOUS AND VENEREAL DISEASES.—We have received the first number of this journal. It is edited by Drs. H. G. Piffard and P. A. Morrow, and is published monthly. It contains an excellent colored lithograph of a case of trichophytosis cruris, several original articles, reviews, selections, and items. Altogether the *Journal* is excellent, and shows judicious editorship.

I.—6.—7.

CARBOLIC INJECTIONS IN HEMORRHOIDS.—In our October issue we gave a sketch of an article on the above subject by Dr. Chas. Kelsey, of New York, in which we neglected to give the strength of the solution recommended by that surgeon, and the amount to be injected. Our attention has been very properly called to this oversight, by our friend Dr. E. J. Blair, of Ontario, and in reply to his query we will state that the formula given is as follows: Pure carbolic acid, one part; glycerine and water, of each, three parts. Of this, inject five drops.

"KOCH'S BUGS" ONLY FAT CRYSTALS:—According to the *Chicago Medical Journal*, Dr. H. D. Schmidt, the distinguished microscopist of New Orleans, has found that Koch's bacilli of tubercle, about which so much enthusiasm has been excited, are nothing but *fat crystals* from the fatty degeneration of the tubercular masses. At least "every form of Koch's bacillus of tubercle can be artificially produced in all its details by Dr. Schmidt, in every tissue that contains fat."

HOSPITAL ELECTION.—We are pleased to notice the election of our old friends, Drs. Joseph Hearn and O. H. Allis, as clinical surgeons to the Jefferson Medical College Hospital, to fill the positions lately occupied by Professors Brinton and S. W. Gross. Both are graduates of Jefferson; the former in 1867, the latter in 1866. It would have been difficult for the Trustees to have made better selections.

At the recent meeting of the American Public Health Association, held at Indianapolis, Dr. Rauch, Secretary of the Illinois Board of Health, paid a well-deserved compliment, when, at the conclusion of Dr. James E. Reeves' report, he said that the work of the West Virginia Board of Health was the best in the Union. The Association, moreover, confirmed this compliment by making Dr. Reeves Vice-President for the ensuing year.

Prof. Austin Flint, Sr., of New York, is to give a course of three lectures on "The Physical Exploration of the Lungs by Means of Auscultation and Percussion," before the Philadelphia County Medical Society. The lectures will be in the Hall of the Society, on November 25th, December 26th and January 13th.

Lecture I.—The True Mode of Study and its Requirements as regards Auscultation and Percussion. The signs obtained by Percussion.

Lecture II.—Auscultation; and the Respiratory Murmur, with its Abnormal Modifications.

Lecture III.—The Rales and the Vocal Signs.

PUT THE DIRECTIONS ON THE PRESCRIPTIONS!—It is scarcely necessary to add a word to what appears, in the current issue, on this subject. An accident(?) which happened in this city several years ago, taught the writer a lesson which has never been forgotten, and however great his hurry may be the “directions” are never omitted. An old practitioner wrote a prescription for “Castor oil, ʒj.” There were no directions. The prescription was written with a dull lead pencil, and was nearly illegible, and the clerk made it out *Croton* oil. The patient took, “as directed,” a tablespoonful, and, of course, died promptly. He, fortunately, had no friends and the matter was hushed up, though about the same time a somewhat similar mistake, also fatal, cost a New Orleans druggist \$20,000.

THE SALICYLATES IN HEADACHE.—Dr. Oehlschlager, of Dantzic, was the first to call attention to the value of salicylic acid in neuralgia. His observations have been abundantly confirmed. Lately Surgeon-Major Roehring, of Hamburg, reports favorably as to the use of salicylate of soda in headache of long standing. We have, ourself, found the effervescent salt exceedingly valuable in sick headache, and we would be pleased to hear from any of our readers as to their experience in this direction.

The Editor of the New York *Medical Record*, who has been advocating the new Code so strongly, in commenting on the recent observation that sulphur is prophylactic to malaria, takes comfort in the thought that there can then be no malaria in Hades.

We did not suppose his remorse was so keen.

FLUID EXTRACT OF LICORICE.—NOTE.—Burroughs’ fluid extract of licorice, for disguising the taste of quinine, can be obtained, by physicians who desire to test it, of Mr. A. E. Angier, Pharmacist, of this city.

OBITUARY.

DIED.—In Paris, Ky., September 19, 1882, of organic heart disease, Dr. John D. Ray, aged 58.

Dr. Ray was a graduate of the University of New York. He first located in Missouri, but in 1862 moved to Bourbon county, Ky., where he remained until his death. He was twice married, and leaves a wife and one son.

OUR ADVERTISERS.

WE call attention to the advertisement of the hot water heating apparatus of Messrs. Backus & Co. Parties intending to introduce any form of heating apparatus into their houses, or to make any changes in apparatus now in use, will do well to correspond with them. We have long had in mind an editorial on the subject of heating residences by hot water, and shall put our intention into effect at an early day.

THE SPERMATIC TRUSS.—We can only repeat what we said in favor of this appliance in the *Recorder* four years ago. It will absolutely prevent erections, while it also protects the organ from friction against the bed-clothes. The excessive secretion, and consequent discharge, of semen being due, in a large proportion of cases, to reflex irritation originating in hyperesthesia of the glans, this truss, by protecting the glans, reduces the secretion and prevents the emission. In those unfortunate cases in which the semen passes away without erection or sexual excitement, this truss will be of no value primarily, but can be used after the tone of the organs has been to some extent restored.

The well known house of Reed & Carnick appear in our columns with a new preparation of beef. If the popularity of the preparations of the house are any guarantee of the future, we know it is a good reliable article.

PETROLEUM EMULSION.—There has for years been a remarkable consensus of opinion, among physicians who have used it, as to the remedial virtues of petroleum; especially in chronic diseases of the lungs and all wasting diseases. The great, and generally insurmountable, objection has been its disgusting odor and taste, which have sufficed to cause the stoutest stomach to rebel and the most determined patient to give up the attempt.

Mr. Angier, of this city, after the expenditure of considerable time and patience, has at last succeeded in skillfully overcoming these objectionable features, and his Emulsion enables patients to easily and pleasantly realize all the benefits to be derived from this remedy. Quite a number of the principal physicians of this city, and surrounding towns, have used the emulsion and all unite in hearty commendation of it.

PINUS CANADENSIS.—Prof. Louis Bauer, M. D., M. R. C. S. Engl., of St. Louis, gives to the concentrated extract of *Pinus Canadensis* his most unqualified commendation as an astringent; it can scarcely require any further affirmation.

NOTES AND COMMENTS.

TESTING THE ABSORBABILITY OF THE STOMACH.—Drs. F. Penzoldt and A. Faber, of Erlangen, have devised an ingenious way of testing the absorbability of the stomach. About three hours after a meal the patient is given gr. ijss. of potassium iodide in a thin gelatine capsule. This is swallowed with a certain definite amount of water. The gelatine capsule must be such as will dissolve in one or two minutes. The patient then, from minute to minute, spits upon a piece of paper, and a drop of fuming nitric acid is added. In the normal absorbability of the stomach a red coloring appears in from six and a half to eleven minutes, and a blue coloring in seven and a half to fifteen minutes. If the stomach does not absorb well, as in dilatation, the reaction is delayed sometimes from one-half to three-quarters of an hour.—*N. Y. Med. Record.*

PESSARY IN RECTUM, AND OTHER MATTERS.—Most of our exchanges are copying, with much gusto, the statement, from the *Nashville Medical Journal*, to the effect that some *homeopath* had introduced a pessary, for retroversion of the uterus, into the rectum. Of course that is all right—irregulars are fair game; but we regulars live in such well glazed houses that we should be a little cautious in the matter of throwing stones. In our own very limited experience, we have known one regular to introduce his pessary into the *bladder*, and another who, in delivering a woman of a baby, made all his examinations *per rectum*, and never knew the difference until the patient remarked on his—to her, at least—novel procedure.

The New York *Sanitary Engineer* has undertaken to print all the important information hitherto published in the National Board of Health *Bulletin*, the publication of which was stopped by the parsimony of Congress. The *Sanitary Engineer*, apart from its own intrinsic merits, deserves the support of all physicians and sanitarians for its laudable enterprise in the premises.

A law forbidding the sale or use of toy pistols has been passed by the Vermont Legislature.

ILLNESS OF SIR THOMAS WATSON.—Sir Thomas Watson, who is now ninety-one years old, is seriously ill and not expected to recover. A stroke of paralysis has prostrated him, but left him in possession of his mental faculties. When stricken down, he calmly remarked to his attendant: "This is the beginning of the end."

THE new college at Chicago, the College of Physicians and Surgeons, opens with a large class. Its fees are said to be only about one-half those of the other two colleges, to which fact some part of its prosperity may be safely attributed.

REFILLING OF PRESCRIPTIONS.—In Wisconsin, any druggist, apothecary, or vendor of medicine is liable to a fine of ten dollars and costs for every time he is convicted of refilling a prescription marked "No Duplicate."

BITTER and nauseous salines are best taken simply diluted with ice water. A mouthful or two of ice water before and after the dose, to blunt the sense of taste, and the dose between them in a wine glass full of ice water, renders it easily taken by most persons,—Squibb's *Ephemeris*.

"**ST. JACOB'S OIL**" appears to be a feeble and badly made aconite liniment, and consists mainly of water, ether, alcohol, turpentine, and a small proportion of aconite with red coloring matter.—*Ibid*.

A CASE OF DEATH FROM SECONDARY HEMORRHAGE, following a stab wound of the coronary artery, is reported from New York. Hemorrhage set in on the fifth day after the wound, and death resulted from the pericardium becoming filled with blood.

Another American medical work is to be read abroad. The *London Lancet* characterizes Prof. Lusk's recent treatise on Obstetrics as the best in the English language.

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JANUARY, 1883.

No. 7.

COMMUNICATIONS.

REPORT OF A CASE OF INTERMITTENT FEVER COMPLICATED WITH ACUTE ALBUMINURIA AND GENERAL DROPSY.

Clinical Remarks delivered in Starling Medical College, November 2, 1882.

BY STARLING LOVING, M. D., COLUMBUS, OHIO.

GENTLEMEN:—As you always receive accounts of clinical experience with seeming approbation, I beg to present this morning, the main points in the history of a case which has fallen under my observation since I last took the liberty to introduce subjects foreign to the regular lecture of the day.

I was requested day before yesterday to visit a patient, a female, who lives three miles from town in a notoriously malarious locality. The message was, “she is very bad with the dropsy, and the doctor has given her up. We wish you to come as soon as possible.”

I found a German woman, twenty-six years of age, belonging to the laboring class; by occupation a domestic servant, but recently married, and since engaged in the ordinary duties of the housewife. She is of medium height, rather muscular, has black hair, dark eyes, and irregular features. Her family history is good, and her own history, until the beginning of the present illness, is that of uniform health with the exception of slight dysmenorrhea. Her husband said, “she was well five weeks ago, when I married and brought her here.”

Three weeks ago she had, without antecedent disturbance, more than

the usual prodromic indisposition a day or two preceding, a chill followed by fever and the other concomitants of an attack of intermittent, which, according to the history given me, assumed the tertian type. She took some medicine, a purgative, and some quinine, with the effect of modifying but not completely arresting the progress of the malady; but instead of regaining health, she lost strength rapidly; became pale, and suffered from increasing derangement of the functions, lost her appetite, was constipated, had scanty urine; and alternately diminished, and excessive perspiration, etc.; and ten days ago, or thereabouts, it was noticed that her face had become puffy and swollen, and soon that the feet and legs were in the same condition from edema. In a short time the abdomen became dropsical; and she was soon reduced to the condition in which I found her; she was in the semi-recumbent posture, being propped on her bed with several pillows, and evidently suffering from extreme difficulty of breathing. Her face was so much swollen as almost to conceal the eyes, the swelling giving to those organs that swine-like expression peculiar to those suffering from extreme oedema of the face. The lips were livid. Skin was pallid and had a mealy look—another peculiarity observed in dropsy from albuminuria. The hands were greatly swollen, the fingers separated, and the nails purple. The abdomen was distended, giving appearance of pregnancy at the ninth month; and examination showed the legs and feet in the same condition as the arms and hands. In short, there was general dropsy.

As already stated, there was extreme dyspnea, due apparently to the hurried circulation, the condition of the lungs, and to the accumulation of fluid in the abdominal cavity. There was a frequent, short, moist cough attended with ronchial sounds and rather abundant expectoration of frothy yet tenacious mucus. The pulse was 115, small and weak. The temperature was 103°. The skin was dry.

There was a degree of dullness on percussion, most distinct over the subscapular regions. Auscultation revealed prolonged expiration with dry and moist bronchial rales in several regions, most distinctly in the subscapular regions, where, in addition, the sub-crepitant rale was very plainly heard.

The sounds of the heart were normal, but the action of the organ was somewhat labored.

The bowels had not moved for forty-eight hours; and the secretion of urine, which had been diminishing for several days, had been reduced to less than six fluid ounces during the fifteen hours preceding my examina-

tion of the patient. A small quantity, about two and a half ounces, remained in the vessel. It was of a dark, smoky color, and had a dense, flocculent, dark gray sediment. The application of heat caused the sediment to disappear, in part, but in turn produced a copious coagulation. The boiling was conducted in a spoon held over a lamp chimney, a clumsy and imperfect method of making the test, but the only available one. The remaining quantity was secured for more complete analysis.

From the history and symptoms, I judged the case to be one of tertian intermittent fever, complicated with general dropsy, including edema of the lungs, bronchitis, and acute albuminuria. The complications had arisen from morbid change in the blood, exposure to cold and damp, continued obstruction of the abdominal veins, and congestion, and probably, also inflammation of the kidneys—the whole, except the bronchitis, being the result of the noxious influence of malaria.

The prognosis was exceedingly grave. It was plainly evident that unless there was prompt relief death must soon occur. If the dropsy increased, the patient would be suffocated. If the secretion of the kidneys continued to diminish she would die from uremia.

Something was to be hoped from the type of the fever. It was reasonable to expect that the paroxysm would subside toward evening, and lessen vascular tension, allowing a respite to the breathing, and partial relief to the secretions, but it was clear that the influence of prompt treatment might be of vast importance, and that such was imperatively demanded by the condition of the patient.

The indications were to shorten the paroxysm and reduce the temperature; to stimulate the secretions of the bowels and skin as much as possible, in order to permit the functions of the lungs and kidneys to be resumed; and, by the influence of quinine, to prevent the recurrence of fever.

Active purgation afforded the most direct method of accomplishing the first of these, and the following was ordered:

R Sulphate of Magnesia.....two ounces.
Sulphate of Iron.....ten grains.
Lemon Syrup, } of each, two fluid ounces.
Water, }
Mix.

S. Give two tablespoonfuls, diluted with water, every two hours, until the bowels have been moved freely.

Meantime the patient was directed to drink freely of lemonade, and tea without milk, and, to be kept closely covered.

The following was ordered for use immediately after the action of the purgative :

R Sulphate of Quinine.....fifty grains.
 Fluid Extract of Jaborandi.....three fluid drachms.
 Tartaric Acid.....one drachm.
 Lemon Syrup, } ..of each, two and a half fluid ounces.
 Water, }
 Mix.

S. Dose, one tablespoonful of the mixture, diluted with an equal quantity of water. The first dose to be taken immediately after the purgative has operated. To be repeated every two hours until further directions.

I had some fear that the mixture containing the quinine might not be well borne by the patient's stomach, but being anxious to have the effect of the antiperiodic as speedily and decidedly as possible, and those of the jaborandi upon the skin, I presumed somewhat upon the patient's habits and susceptibilities, hoping meantime that she would not discover it to be worse than some concoctions she had taken before.

The result was entirely satisfactory. I was gratified on my visit yesterday, to find that the fever had entirely subsided, that all the symptoms had lessened in severity. The salts had operated freely after the third dose, and the quinine mixture had not disturbed the stomach, although the patient complained of its unpleasant taste.

The patient had lost the expression of extreme distress, the pulse was eighty, full, soft and regular, the skin was moist, and there was less swelling of the face and extremities. The breathing, though not natural, not so laborious. The cough was less frequent and loose. There had been no increase of edema in the lungs. The secretion of urine had materially increased, and had more nearly the normal appearance, though it was still dark and had a large sediment.

These results were due in part to the termination of the febrile paroxysm, and in part to the effects of the medicines.

There were no evidences as yet of cinchonism, although the quinine had been taken regularly; and while the skin was moist, there had not been, as yet, free diaphoresis.

The remaining indication was to prevent the paroxysm of fever, to be expected to-day, and the patient was directed to continue the quinine and jaborandi until cinchonism should be fully established. She was allowed such nourishment as she might choose, and to take some beer, which she craved.

To-day I found there had been no paroxysm of fever, and that cinchonism had been fully established. The patient was quite deaf, the pulse as soft, rather weak and not more than seventy-six beats to the minute. Sixty-five grains of quinine had been taken. There had been profuse sweating during the night and morning, and the skin was still secreting freely. The secretion of the kidneys had materially increased, and the urine had assumed nearly the normal appearance. The dropsy had in a great measure disappeared from the face, and there was less swelling of the abdomen and extremities. The cough had almost disappeared, and only a few moist rales could be heard on application of the ear to the chest.

I regarded the patient as safe, but, as a matter of precaution, directed that three doses of quinine and jaborandi be administered at intervals of two hours on Saturday morning, the first to be given at six o'clock.

Careful analysis of the specimen of urine obtained at the first visit settled all doubts as to the condition of the urine. The application of heat and nitric acid showed the presence of albumen in large quantity. A specimen obtained yesterday, contained less, but still a large quantity. To-day there is still less but an appreciable amount. With the cure of the fever, I expect this abnormal constituent to disappear; for from the results, so far, I am convinced that the opinion formed at the time of my first visit was correct. The state of the kidneys is due to the influence of malaria, and not chronic inflammation.

This case is of a class not unfrequently observed by practitioners in malarious regions, and a moment's reflection on the effects of malaria upon the blood, and of those of a paroxysm of ague upon the abdominal organs, especially upon the spleen and liver, makes it a matter of surprise that they are not of more frequent occurrence.

With each succeeding paroxysm of the fever, the spleen, liver and other abdominal organs are filled with blood. The portal circulation for the time is almost arrested, and the secretions of the liver, pancreas and kidneys become deranged.

The congestion of the liver is not entirely relieved during the intermission, and the portal circulation, though partially restored, remains obstructed, the kidneys become so much engorged as to render normal secretion impossible; and, finally, there is effusion into their connective tissue, and edema, or a grade of inflammation, and albumen transudes. Meantime, owing to the condition of the blood, the obstructions named, and the rapidly increasing general debility, edema of the lower extremi-

ties and of other parts supervenes, and sometimes general dropsy, as in the case under consideration.

Extreme cases like ours are not very common, but are seen every now and then. Edema of one or another part, especially of the lower extremities; and albuminuria, or some form of lithiasis, are every day occurrences from malarial infection; the two last, unless recognized early and promptly treated, sometimes resulting in chronic albuminuria or stone.

The lessons from such cases are several.

1. The practitioner should always remember that, while an attack of ague is commonly considered as without danger, the consequences may prove exceedingly grave.

2. A second paroxysm, even of the mildest form, should never be permitted, if it be possible to prevent its occurrence.

3. We have more direct control of malarial fevers than of any other form of acute disease, and are culpable if we fail to exercise that control without delay.

4. The fact that such cases as that which we have under consideration do occur, and as often from mild as from severe attacks of fever, should make us the more watchful, especially when there is decided anemia, or edema of any part.

5. We should not forget when cases of albuminuria with dropsy come under our care, that malaria may cause both, nor mistake such for cases of Bright's Disease, as happened in my experience on one occasion, as I have already mentioned to you.

6. Keeping the possible dangers in view, we should never cease our care of patients who suffer from malarial fevers until we are sure they are safe from recurrence of the paroxysms, and until we know that the nutrition is in process of restoration.

7. Preparatory treatment is not necessary nor desirable in the majority of cases of intermittent, nor in remittent fever, but occasionally one meets with a case of either in which it is imperatively demanded, in order that the antiperiodic may be absorbed and have effect.

I am sure, that without the antecedent influence of the purgative, but little could have been obtained from the administration of quinine in the present case.

Our case may yet prove to be chronic in character, but its history and the changes which have occurred in its progress during the last two days lead me to think it acute and transitory.

I shall watch the patient and report her condition when sufficient time

has elapsed to prove or disprove the correctness of my opinion. Mean-time in order to prevent the recurrence of the fever and to build up the patient's health, I shall prescribe for her arsenic and the tincture of the per chloride of iron.

Dcc. I.—There has been no recurrence of fever. The dropsy has entirely disappeared. The urine is normal; and although the patient is yet pale and somewhat feeble, she is feeling well and is at her work.

*REPORT OF FOUR CASES IN WHICH APHASIA WAS A
PROMINENT SYMPTOM, WITH COMMENTS.*

BY S. C. DUMM, M. D., CONSTANTIA, O.

About four years ago Mr. J., aged 67, had some financial difficulty which worried him very much, so that he passed sleepless nights, and, as a consequence of the mental strain, had an attack of fever of an intermittent character. I prescribed for him and he improved somewhat, but did not recover his accustomed health.

About one month after this time I met him, and noticed that he looked rather pale and emaciated. On inquiring as to the state of his health, he told me that he was very weak and thirsty, and was drinking enormous quantities of water, and passing a corresponding amount of urine. He wanted to know what I thought was the matter, and I answered that the probabilities were that he had an attack of diabetes.

I ordered him to drink skimmed milk in place of water, and gave him a prescription composed of dilute phosphoric acid, pyrophosphate of iron, and strychnia, in appropriate doses. I noticed at that time that his right arm and leg were weaker than the left, but it was not a well-marked case of hemiplegia.

He was unable to walk for a week or ten days, without the use of canes to steady him, after commencing treatment. If he turned his ankle in the least, by stepping upon an uneven surface, he would invariably fall down. In walking, he would shy off to the right, so that when starting for a point opposite where he stood, he would follow the wall around.

He continued to drink large quantities of skimmed milk, during the day and night, and also indulged freely in the richest diet. This was in the fall months, and after the first month of treatment he began to improve in strength, and by spring was able to go about and do business in the way of buying and selling stock, etc.

The diagnosis of diabetes mellitus had been confirmed, and, as I could not promise him a permanent cure, he passed from my care during the summer. At this time, although the weakness of the right side had improved considerably, the side was never as strong as before.

In the following fall, Mr. J. sent for me again. At my first visit, I noticed that he had some difficulty in remembering words, and to express his thoughts. He would seem, at first, to lose one or two words in each sentence, but would always supply it by some unmeaning word. He continued to grow weaker and more aphasic until his language was nothing but a continuous jargon of unmeaning terms and terribly constructed sentences. It was impossible to make out anything by what he said. For two or three months he seemed to know what he wanted to say, but was unable to remember proper words to express it.

After being in this condition for about three months, he became hopelessly insane, and remained so until death, which took place in the following March. No post-mortem was permitted.

My second case was in a man 80 years of age. He had been gradually losing his memory for two or three years. Otherwise he had fair health for a man of his age, except occasionally an attack of facial neuralgia. He was aphasic for about one month, when he became insane and in another month died. He had no symptoms of paralysis. When I would ask him to put out his tongue, he would show the palm of his hand.

The third patient is still living, and is in his 90th year. He is subject to neuralgia and rheumatism. He has been aphasic for nearly two years, and is more at a loss for words in the last two months than ever.

One year ago last winter (1880-81) he imagined that he was away from home, and did not know his own son and daughter. During most of that winter he was annoyed with a sensation of dryness of the fauces and hard palate. He improved when spring came, and had fair health during the summer following. His attacks of rheumatism have only taken place during the last year, and since that time he has had no neuralgia. The swelling of the joints is confined to the right wrist and left knee. He tends off to the right in walking, as in the first case. When asking a favor of any one, he asks them to increase his faith. He seems to think now that he is in New Hampshire, his youthful home, and when his neighbors call he wonders how they have got where he is. His appetite is pretty good, and he sleeps well, but keeps up a clamoring for something all the while.

The fourth case was in Miss F., aged 8 years. September 24, 1882,

she had a chill followed by continuous fever, up to the time of my visit, which was at 9 o'clock in the evening of the 26th. Her pulse was 140; tongue heavily coated, with a light brown fur. She had no pain in any part of the body, except in the frontal region, and did not complain seriously of that. She looked bright and intelligent but I noticed that she answered questions slowly, hesitating a few moments before attempting any reply to what was asked her. She had a recent scar about three-fourths of an inch in length and one-fourth in breadth, in the center of the left frontal region, which had been caused by a fall against the corner of a log. The wound had bled very freely, but no further notice was taken of it at the time, nor since. There seemed to be no depression, of the external table at least. This injury took place about six weeks before her sickness.

She had had two chills in about two weeks after the injury was received, but as nothing was given to prevent their continuance, it would seem that they were not malarial in their nature, as was supposed by her parents.

She had been eating a good many peaches, and had vomited on the day of my visit.

Not being fully satisfied at my first visit that the injury was the sole cause of her condition—as the mind was perfectly clear—I prescribed a small Dover's powder every three hours. Just after the second one was taken, which was 12 o'clock at night, she had a convulsion, the movements being confined principally to the right half of the body. This was followed by all the symptoms of right hemiplegia, but this condition passed off to a great extent during the next twenty-four hours. The paraparesis affected the throat, causing great difficulty in deglutition. Her eyes and head were drawn to the left. After the lapse of one day, she could use her limbs and throat, but was completely aphasic. She would look around intelligently, and acted in every way as though she knew us, but she had forgotten language entirely, or was in some way unable to express it. She made no effort to put out her tongue but once, and that was about the third day, when she did it slowly but completely, showing that her throat and tongue were not completely paralyzed. She could turn herself in bed, but could no more speak than a child a day old. Her pulse, during the convulsion, was 160, but under treatment came down, and fluctuated between 88 and 120. On the eighth day a worm was found in her mouth, and *santonine* was given, which was followed by the expulsion of six worms, but with no alleviation

of the symptoms, as had been hoped for. She wasted rapidly in flesh, and had a small fever sore on her right hip. Heart failure took place, and she died on the eleventh day of her illness. Post-mortem was not permitted, but I have no doubt that the injury, from the symptoms present, was the prime cause of her death.

Practically, there is nothing gained by giving the clinical history of such cases, except the satisfaction a physician takes in knowing just what the difficulty is. The value of treatment in such cases amounts to nothing, except on general principles, but he who is able to rightly diagnose such cases will often save his patients much needless medication. The localization of the functions of the brain is an interesting question, and one that is attracting the attention of neuro-pathologists in every country. Ever since M. Broca, in 1861, announced his conclusion that the seat of the faculty of articulate language was in the second and third frontal convolution, or especially in the posterior third of the left anterior lobe of the brain, a new interest has been awakened in this matter, and in the subject of aphasia, or that condition produced by an affection of certain portions of the brain, by which the idea of language is lost or its expression impaired. The part of the brain mentioned, is nourished by the left middle cerebral artery. Obstruction of this artery would deprive this portion of the brain of its nutrition, and as a consequence, there would be aphasia. Obstruction might, and often does, take place from an embolus, derived from valvular disease, as in rheumatism. This must have been the cause in my third case, it being complicated, or rather preceded by rheumatism. There was also irregular action of the heart. Dr. Hammond says that the gray matter of the brain presides over the ideas of language, and hence, over the memory of words. When, therefore, the gray matter of the brain is only affected, we will have no hemiplegia, and no difficulty in articulation, but there will be a loss of memory for words, as in my second case. He seemed to be able to speak, but could not use the right word. He had no paralysis.

If the corpus striatum, which contains the white fibrous tissue connecting the hemisphere with the cord, or any other part of the motor tract, be involved, we will have paralysis on the opposite side, as in my first, third and fourth cases. There are, therefore, two varieties of aphasia, the amnesic and ataxic; the former where the gray matter only is involved, and the latter where the white fibrous nerve tissue is affected, and there is paralysis.

Dr. Seguin states that when the faculty of speech is affected to any

extent, or the symptoms of amnesic aphasia exist, it is safe to conclude that the lesion involves one of three situations, viz: The anterior convolutions of the island of Reil, the base of the third frontal convolution, or the white substance lying between the third frontal convolution and the base of the cranium.

The subject of aphasia is treated of in Rosenthal's "Diseases of the Nervous System," under the head of embolism and thrombosis. He says: "It is another characteristic of cerebral embolism, and from a clinical point of view we have a better appreciation of the various forms of aphasia, its connection with the hemiplegia, of motion and sensation, and its appearance in consequence of embolism, softening or other lesion of the brain, in typhoid fever, acute exanthemata, erysipelas, Bright's disease, diabetes, hysteria, catalepsy, epilepsy, etc. The disease not unfrequently appears temporarily in the course of cerebral diseases, and is often passed unnoticed; at these times it is an intermittent symptom, but more often persistent." •

There is no doubt but that it is a premonitory symptom of insanity. Two of my cases have ended that way. The fact that aphasia, or the lesion by which it is produced, is more often connected with right hemiplegia, is accounted for by the fact that the left middle cerebral artery is more apt to be plugged by an embolus, on account of the peculiar conformation of the arteries at the base of the brain, and it is by an embolus that it is generally produced. Hence it is only a symptom of a pathological process, which may be easily understood; a localized disease of the brain.

"Where the lesion is on the left, as it generally is in aphasia, the loss of the faculty of speech, Dr. Ferrier says, is accounted for by the unequal preponderance of the left hemisphere in the inclination of voluntary actions. The left hemisphere, like the right side of the body, is the leading or driving side, so that a lesion of the left side is like the loss of the right hand; it requires long education to enable the person to accomplish with his left hand all the delicate operations or manipulations of which the right hand is capable. The leading action of the left hemisphere may, however, be merely an accident of education or necessity, and there is no reason why articulate speech should not be a function of the right side."

Although I did not have an opportunity of making post-mortems in my cases, we may arrive at the following conclusion in reference to them from the symptoms: In the first case there was a lesion affecting the gray

and white fibrous tissues, because we had paralysis of motion, to a limited extent. The power to utter words was not gone, but only the memory of the proper word. There was no paralysis of the organs of speech, for he talked incessantly. There was impaired muscular power over the right arm and leg, but not to any great extent. His memory for words was gone, hence his trouble was principally the amnesic form of aphasia. There was no doubt, then, slight lesion of the white fibrous tissue with great lesion of the gray cells.

In the second case, there being no paralysis, the lesion would be confined to the gray matter; hence this was a case of the amnesic form.

In the third, there being slight impairment of muscular power in the right upper and lower extremities, we would infer that the lesion affected both the gray and white matter in that portion of the brain.

In the fourth case there was a complication of the amnesic and ataxic forms, but just what the pathological condition was, I am unable to say.

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A CASE OF TYPHOID FEVER TREATED WITH ERGOT.

BY F. JACKMAN, M. D., INDIANAPOLIS, IND.

M. Debove, of Paris, has employed ergot in the treatment of typhoid fever in all its forms for seven years, with results which warrant a conclusion strongly in its favor. In a report to the Academy of Medicine, he recommends fifteen grains to be given in two doses, but unfortunately gives no explanation of the manner of exhibiting the remedy. In one series of twenty-four cases, of which eight were very grave, eleven serious and five of moderate severity, only one proved fatal. In another series of six cases, of which one was very grave and five moderately serious, all recovered. In still another series of six cases, three being very grave, two serious and one of moderate severity, all but one recovered.

I am sorry I did not keep a daily record of the case I am about to report, as is generally my custom, but I hope my notes of the case will be of some interest to the profession, as it shows very clearly, to my mind at least, that the medicine given had at least a mitigating influence upon the course and severity of the disease, if not a positively curative influence. I cannot say that it shortened the course of the disease, but I do think it was of use in controlling the fever and hemorrhage of the bowels.

Ella B., aged 10 years, light complexion, mental temperament, and

rather delicate, had been sick in bed three days, when I first saw her, with fever in afternoon, intense headache, occasional epistaxis, anorexia, considerable jaundice, bowels not moved for three days, and slight right iliac tenderness and gurgling on pressure. Temperature at 7 A. M., $104\frac{1}{2}^{\circ}$ F.; pulse 110. Thinking I had a malarial trouble, I ordered two grains of calomel and one grain of compound jalap powder until a good movement of the bowels took place; at the same time three grains of quinine and one-eighth grain capsicum was given every three hours. The next morning the temperature was 102° F., pulse 106, and in the evening temperature $104\frac{1}{2}^{\circ}$ F., pulse 110. The purgative had produced considerable action of the bowels. The tenderness and gurgling in the right iliac region was more marked. Being satisfied that this was a case of pure typhoid fever, I discontinued the prescriptions and wrote the following:

R. Quininæ sulph. grs viij.
 Acid. salicylici, } aa. grs. xvi.
 Ext. ergotæ, }
 M. Ft. capsules no. viij.
 Sig. One every three hours.

This was alternated every three hours with five drops of dilute nitrohydrochloric acid in water, making a dose every hour and a half.

Next morning the temperature was $101\frac{1}{2}^{\circ}$ and pulse 110. In the evening, temperature 104° , pulse 110. The treatment was continued one week in this manner, together with cold baths in the afternoon and evening, the patient being put into a tub of cold water and thoroughly bathed, during which time the temperature gradually diminished until the evening temperature was 100° F.

One notable feature of the case was that the pulse kept up to 110 in the morning and 116 in the evening throughout the whole course of the disease—twenty-one days—but was strong and full. Thinking the fever was about to an end, I left off the capsules and ordered:

R. Spts. terebinth. ʒj.
 Mucil. acaciæ ʒij.
 M. Sig. Teaspoonful every three hours.

The acid was continued. The next evening temperature was $104\frac{1}{2}^{\circ}$, pulse 116 but weak and thready. Diarrhea excessive, with pain in abdomen, anorexia complete, and some delirium. The appetite during the past week had been good, and the patient was nourished with the usual typhoid diet. Regarding it as a temporary reaction the treatment was continued another twenty-four hours, when I found her in much the same

condition. The turpentine was replaced with the ergot capsules and continued five days, during which time the symptoms above referred to all gradually diminished until the evening temperature was $99\frac{1}{2}$, pulse 116 and strong. The appetite returned and diarrhea stopped the day after the continuation of the ergot. Again I left off the capsules and gave the turpentine as before, only to find the temperature at the end of twenty-four hours $104\frac{1}{2}$, pulse 116 and thready, anorexia, great pain in the bowels, great diarrhea and considerable hemorrhage with every passage. Resumed the ergot capsules, with the same result as before, until the end of twenty-one days, when recovery had unmistakably taken place and all medicine was left off.

I should have stated that whisky was given *ad libitum* throughout the course of the disease.

I should be inclined to think that the quinine and salicylic acid exerted some influence, if I had not before tried them in all my other cases, both separate and combined, and in both large and small doses, without any apparent benefit. Possibly it was the combination that was so beneficial.

SOCIETY PROCEEDINGS.

The Ohio Valley Medical Society met in the city of Gallipolis, Ohio, Monday, November 7th, in regular semi-annual session, the President, Dr. C. R. Reed, in the chair. The Secretary being necessarily detained at home, Dr. E. G. Alcorn was chosen Secretary *pro-tem*. The following members were present: Drs. Reed, Tobey, Newton, Hunson, J. E. Sylvester, William Sylvester, Holcomb, Crummit, Mills and Jacobs. After the usual preliminary business, Dr. E. G. Alcorn presented an interesting and instructive paper on the subject of "Asthenopia," after which Dr. J. E. Sylvester reported a case of "Locomotor Ataxy," cured by administration of strychnia, which was well received; during the discussion of which the therapeutic effects of strychnia were considered at length.

At the evening session the general subject of "Quackery" was discussed, and a letter from Prof. J. T. Whittaker, of Cincinnati, relative to the subject was read. The following resolution was then offered by Dr. J. E. Sylvester, which was laid over for discussion until to-morrow:

Be it resolved by the Ohio Valley Medical Society, That we consider reprehensible the practice of certain medical journals of admitting the adver-

tisements of articles put up by manufacturers of patent medicines, and that we demand as a part of the consideration of our support, that such advertisements be hereafter omitted.

Resolved, That the Secretary be directed to transmit a copy of these resolutions to the publishers of the *Lancet and Clinic*, the *Obstetric Gazette*, and the COLUMBUS MEDICAL JOURNAL, these being journals of general circulation among the profession in this valley.

After which the Society adjourned until to-morrow morning, at 8 o'clock.

WEDNESDAY, November 8, 8 A. M.

Society met as per adjournment. Additional members present, Drs. Johnson, Luckey, Knight, Fravel, Guthrie and Bishop. The latter being Secretary, and having brought the minutes of previous meeting, the same were read and approved.

On motion of Dr. Tobey, the following resolutions, offered by Dr Mills and adopted at the last meeting, were ordered published, viz.:

Resolved, That the Ohio Valley Medical Society has learned with deep regret of the death of Dr. C. H. Needham, and that they hereby wish to express their high sense of his virtues, talents and professional merit.

Resolved, That this Association has lost one of its zealous and devoted members and the community a valuable citizen.

Resolved, That the warmest sympathies of this Association are hereby most respectfully tendered to the family and friends of their deceased associate, and that a copy of these resolutions be published in the city papers, and also in the COLUMBUS MEDICAL JOURNAL.

The Committee on Admissions then recommended for membership Dr. W. W. O'Neil, of the Kentucky School of Medicine, Class of 1879. A ballot being had, he was declared elected.

Regular business being called, Dr. Fravel presented a report on the "Use of the Ophthalmoscope." The section of Surgery presented verbal reports of three cases of injury to the brain, resulting in death in all three; in two of which trephining was employed, and in one it was not. Considerable discussion was provoked by this report, in which the members generally engaged. The Society then adjourned to meet at 2 o'clock P. M.

At this session the usual financial business was transacted, and Jackson C. H., Jackson county, was selected as the place of the next meeting, which was fixed for the first Wednesday and Thursday in May, 1883.

Dr. Knight then presented an admirable paper on the subject of

"Theory and Practice," which abounded in salient points, and on motion of the Secretary, the author was requested to have the same published in the COLUMBUS MEDICAL JOURNAL.

The resolution yesterday offered by Dr. Sylvester was taken up, and, after some discussion, with the consent of the second, was withdrawn. On motion of the same gentleman, the Secretary was directed to furnish the COLUMBUS MEDICAL JOURNAL and *Cincinnati Lancet and Clinic* with a resume of proceedings. The Chairman then announced as the Chairmen of the several sections for the May meeting, as follows:

Surgery—Dr. Eakin.

Practice—Dr. Crummit.

Obstetrics and Gynecology—Drs. Mills and Johnson.

Nervous Diseases—Dr. Tobey.

Phys. and Hygiene—Dr. Luckey.

Chem. and Mat. Med.—Dr. J. E. Sylvester.

Typhoid Diseases—Dr. Holcomb.

Necrology—Dr. William Syvester.

Medical Jurisprudence—Dr. Jacobs.

Ophthalmology—Dr. Fravel.

Otology—Dr. Alcorn.

Public Lecture—Dr. Knight.

J. C. BISHOP, M. D., Secretary.

MIDDLEPORT, O., November 1882.

HICCOUGH LASTING TWENTY-SIX WEEKS.—In the *Brit. Med. Jour.*, Dr. A. W. Foot details the history of a lad, aged 15, whom he was called to see after he had been hiccupping, without ceasing, except during sleep, from November 5, 1880, to April 6, 1881. The attack came on quite suddenly. He had previously suffered from shorter attacks on two occasions. A month's treatment with hemp and iodoform cured the patient. The average rate of hiccupping was 840 per hour, and it lasted, without intermission, except during sleep, for twenty-six weeks.—*Lond. Med. Record*,

SELECTIONS.

MEDICINE.

THE DOCTRINE OF DESQUAMATION.—There is hardly any disease in regard to which diagnosis is at once so difficult and important as scarlet fever. All authors agree in saying that almost every prominent symptom of it may be wanting. All the symptoms of the earlier stages may either be absent or may be overlooked—sickness, sore-throat and rash. And even the temperature, judged by one or two observations, may be below 100° . All authorities describe, and all practitioners are familiar with, cases in which no suspicion of diseases exists until the occurrence of desquamation, in circumstances which leave no doubt that it is only a part of scarlet fever. But surely desquamation itself is also a most variable process, so variable as to excuse a good deal of the variety of opinion on it, which undoubtedly exists. It may be almost entirely absent, it may occur out of proportion to the amount of rash, it may be long delayed, or it may extend over a very variable period. The recent correspondence was based on the case of a boy at a large public school near London, whose scarlet fever was detected only by close observation, the amount of rash being small, and the whole attack unusually light. The medical officer of the school gave his sanction for the boy returning home three weeks after the attack, who never had any sign of desquamation. The father having other children at home during the Christmas holidays who had not had scarlatina, naturally felt afraid, and wisely (we presume with due precautions for the boy and others) removed him to an infirmary specially intended for such cases. Between two and three weeks later, and six weeks from the commencement of the attack, when the boy should have returned to school, he was found by a practitioner to be peeling. The medical man of the school considered the peeling to be unconnected with the attack which he had at school, and to be due to eczema. The father of the boy associated it with the attack that had been so well diagnosed at school, and saw in it a justification of his caution in not allowing his son to return home. The majority of authorities will be disposed to agree with Dr. David Page, that patients recovering from scarlet fever may have their desquamation much deferred, and that

certainly they are not desirable as members of society for at least eight weeks. This is very hard, especially in cases where the disease is slight, where there is no sense of illness and but slight or no appearance of desquamation, but it is sound doctrine. The precautions may be excessive, but the case is one for great caution. Still it must be admitted that even among authorities there has been a variety—not to say looseness—of teaching which goes far to explain, especially in connection with the acknowledged variations in the process, the view taken by the medical officer of the school. Let us notice only a few that are at hand. Trousseau says: “Desquamation in scarlatina is not very well understood by the majority of physicians.” He instances a case in which, though at the seventy-second day, it was still going on. Trousseau would have been apt to regard even Hebra as unsound, for Hebra speaks of desquamation as ending at the “end of the third week.” Dr. J. Lewis Smith, a very good observer, of New York, speaks of desquamation as succeeding the disappearance of the eruption and occupying “several days.” Mr. Malcolm Morris says it begins in the latter part of the second week, but may commence as the rash fades, or not until the end of the sixth week. Dr. Bristowe says the period of desquamation is of various duration. “It is sometimes completed in one or two days, not unfrequently extends over a week or two, and occasionally is prolonged for several weeks.” Whether difference of opinion is sound excuse for difference in practice, the variety in the process itself and the occasional instances in which it is deferred indicate the safety of a rule of exclusion of at least six weeks, and if possible eight. Parents and patients will often rebel against this hard doctrine, but, considering the gravity of the disease, it is a safe one for medical men to hold. A correspondent reminds us that all desquamation is not scarlatinous. He described one case in which it seemed to result from the administration of turpentine for hematuria. This suggestion is one to be remembered, when sanitary law and professional duty in connection with desquamation are often both delicate and difficult.—*Lancet*.

FLOATING KIDNEYS.—Mr. Lawson Tait does not believe in the existence of this condition. He says: “I put the floating kidney theory altogether on one side, because I have never seen such a thing, either in life or in a museum, nor have I met any one who has. In fact, I have no belief in its existence as a pathological incident.” An opinion widely at variance with that of a host of competent pathologists and clinicians.

THE ANTI-FAT DIETARY.—Our corpulent friends may be interested in the report of Mr. Joseph Harrass's attempts to get rid of his superfluous burden of flesh, especially as the dietary followed does not seem, on the face of it, to be an objectionable one, and has not proved injurious to health in his case. The facts are stated in the *Herald of Health* as follows:

He was corpulent, had irregular and feeble action of the heart, tendency to fainting, difficulty of breathing, and many disagreeable sensations in the head indicative of nervous exhaustion. Height, five feet six inches; normal weight, one hundred and fifty pounds; age, fifty-nine; weight at beginning of treatment, two hundred pounds. Began treatment October 8th. Treatment as follows: Breakfast—Vegetables, brown bread (toasted); water, with lemon juice, and occasionally oat-meal. Dinner—Vegetables, brown bread, water, and plain pudding. Supper—Brown bread (toasted), stewed fruit, and water. No tea, coffee, cocoa, or milk, except skimmed, and only a trifle of butter. Result:

End of October weighed.....	187 lbs.
“ November weighed.....	182 “
“ December weighed.....	177 “
“ January weighed.....	174 “
“ February weighed.....	173 “
“ March weighed.....	170 “
“ April weighed.....	168 “
“ May weighed.....	166 “
“ June weighed.....	166 “
Present weight.....	150 “

All the distressing symptoms have been relieved, and the patient is so well he can again carry on his business. His physical and mental strength have been greatly improved.

Mr. Harrass says he has suffered no serious discomfort from his diet, except when away from home, and he feels as if he had learned an important lesson as to how to reduce his corpulence—which has been such a source of discomfort—and once more enjoy life.—*Boston Jour. of Chem.*

RULES FOR EXAMINATION OF URINE.—1. Sediment in the urine has no significance unless deposited within twenty-four hours.

2. Albumen in the urine does not indicate kidney disease unless accompanied by tube-casts. The most fatal form of Bright's disease—contracted kidney—has little or no albumen.

3. Every white crystal in urine, regardless of shape, is a phosphite, except the oxalate of lime, which has its own peculiar form, urine alkaline.

4. Every yellow crystal is uric acid if the urine is acid, or a urate if the urine is alkaline.

5. Mucous casts, pus, and epithelium signify disease of the bladder (cystites) or of other parts of the urinary tract, as determined by the variety of epithelium.

6. The urine from females can often be differentiated from the urine of the male, by finding in it the tessellated epithelium of the vagina.

7. Hyaline casts (narrow), blood, and epithelial casts signify acute catarrhal nephritis. Much albumen.

8. Broad hyaline casts and epithelial dark granular and oil casts signify chronic catarrhal nephritis. At first, much albumen; later less.

9. Hyaline and pale granular casts and little or no albumen signify interstitial nephritis.

10. Broader casts are worse than narrow casts, as far as diagnosis is concerned, for the former signify a chronic disease.

11. The urine should be fresh for microscopical examination, as the micrococci will change hyaline casts into granular casts or devour them entirely in a short time.

12. Uric acid in the urine may in Trommer's test for sugar form a protoxide of copper, thus often deceiving the examiner in the belief that he has discovered sugar. Thus when urine shows only a trace of sugar, other methods of examinations, besides the Trommer's, must be used—preferably the lead test.

13. The microscope gives us better ideas of the exact condition of affairs in the examination of urine than the various chemical tests. Therefore the time has come when every true physician should know how to handle a microscope.—Dr. Formad, *Louisville Med. News*.

THE PAINLESSNESS OF DEATH.—At birth the babe undergoes an ordeal that, were he conscious, would be more trying than a most painful death; yet he feels it not. Born in an unconscious state, the brain incapable of receiving conscious impressions, his entrance into this hitherto unknown world is accomplished during a state of oblivion, known as Nature's anesthesia.

“Painlessly we come, whence we know not—
Painlessly we go, whither we know not!”

From the earliest period of human history death has been considered as necessarily accompanied by pain; so general is this belief, that the terms "death agony," "last struggle," "pangs of death," etc., have been in almost universal use in every age and under all conditions of society.

Nothing could be more erroneous; the truth is, pain and death seldom go together—we mean the last moments of life. Of course, death may be preceded by weeks or even months of extreme suffering, as occurs during certain incurable diseases.

So exaggerated has been this notion that it has been considered an act of humanity to anticipate the "last struggle" by violence; for ages it was customary among the lower classes of Europe to hasten death by suddenly jerking the pillow from beneath the head of the dying, thus throwing the head backward, straining the pharyngeal and thoracic muscles, rendering the respiration, already difficult, shortly impossible. A Venetian ambassador, in the time of Queen Mary, asserted that it was a common custom among the country-people to smother the dying by means of a pillow placed over the face, upon which leaned or sat the nearest relative. This was founded upon the pious belief that a short road was the best one. This custom was handed down from generation to generation, parents performing it for their children, and *vice versa*. But, perhaps, the saddest privilege ever allowed the near friends of a dying man, occasionally occurred during the reign of Queen Elizabeth, when through executive clemency—in executions by hanging—they were permitted to grasp the feet of the suspended criminal, and, by clinging to the extremities, precipitate their additional weight on the body, thereby hastening strangulation. It is needless to say that these theories are false in both conception and practice. Death is a physiological process, and like all other animal functions should be painless.—DR. THOMAS D. SPENCER, in *Popular Science Monthly*.

MEDICINAL ERUPTIONS.—Van Harlingen has done a good work in collating the literature of medicinal eruptions. As a result of the internal administrations of arsenic, nearly all lesions of the skin, from a vesicle to a carbuncle, have been reported. But, as many of these arsenical(?) eruptions were associated with the administration of the drug in very small quantity, and as some occurred only once and persisted after the discontinuance of the remedy, we can hardly refrain from regarding them as mere co-incidences. Herpes appears to be the only skin affection

which a number of careful observers have ascribed to the internal use of arsenic. The doctrine that zoster may be of arsenical origin, is certainly supported by good authority, but from our own experience, we should be inclined to argue with Dr. White, that observations have not as yet been sufficiently numerous to prove that the alleged connection is more than accidental. The eruption resulting from belladonna is almost invariably of an erythematous character, usually appearing first upon the face, neck, and upper portion of the body, and sometimes involving the whole cutaneous surface. The resemblance of this rash to that of scarlatina is most striking, and, as in one reported cure the patient felt a severe heat in the throat, it is conceivable that an error in diagnosis might be readily made. The bromine eruption resulting from the bromide of potassium, sodium, ammonium, or lithium, is commonly pustular in character, and is frequently spoken of as bromic acne. In some cases, it has been papular, bullous, and even warty. It occurs in both sexes and at any age, but is especially liable to appear in patients with a thick, greasy skin. It may occur not only upon the face and shoulders, the favorite seat of ordinary acne, but also upon the hairy portions of other parts of the body, showing a tendency to localization, similar to that manifested in iodine and tar eruption. The characteristic eruption of copaiba (one which occurs with inexcusable frequency in the practice of many physicians) is usually erythematous or urticarial in form. It is usually seen upon the hands and arms, but occurs upon the abdomen and lower extremities. Cubebs, when administered alone, rarely causes cutaneous disturbances. The lesions resulting from iodine are exceedingly varied. The most striking and characteristic forms are the bullous and purpuric. Mercury produces no very characteristic eruption, and in nearly all of the cases reported the rash has been erythematous or scarlatiniform. Of course the dermatitis which is so often produced by the free external use of mercurial ointment is not taken into consideration by the writer as a medicinal eruption. Quinine likewise produces an erythematous eruption, as a rule. In some cases it is vesicular and even hemorrhagic. The chief feature of the quinine eruption appears to be its tendency to attack the skin of the scrotum and genital regions.—*N. Y. Med. Jour.*

SURGERY.

SUCCESSFUL TRACHEOTOMY FOR DIPHTHERITIC CROUP IN A CHILD ELEVEN MONTHS OLD.—Dr. George F. Shrady, the accomplished editor of the *Medical Record*, reports the case in the *Record* of Nov. 4th. Tracheotomy in children under two years of age is so seldom successful that it has been regarded by some as an undesirable, if not unjustifiable, operation. Dr. S. has, however, collected a few cases similar to his own, which he thinks the first of its kind reported in this country.

Age of Patient.	Operator.	Permanent removal of tube.	Reference.
7 months.....	Langenbeck.....		{ Langenbeck's Arch kiln, Chir., XXI., p. 253.
7½ "	{ Joseph Bell, Edin- burgh, Scot.		{ Edin. Med. Jour., 1861, p. 956.
8 "	Dr. Elias, Breslau.....	33d day...	{ Dub. Jour. Med, Sci., June, 1879, p. 560.
10 "	M. Baizeau, Algiers....	10th " ...	{ Gazette des Hopitaux, 1867, p. 397.
10 "	{ M. Bourdillat, Paris, France.	15th " ...	{ Union Medicale, June 8, 1872.
10 "	{ J. Cooper Foster, London, Eng.		{ Brit. Med. Jour, March 25, 1871.
10 "	{ W. S. Greenfield, London, Eng.	22d day...	{ St Thomas' Hospital Rep., 1878, p. 259.
11 "	{ Geo. F. Shrady, New York.	13th " ...	{ Medical Record, N. Y., p. 512.
1 year	M. Dujardin, Lille.....	8th month.	{ Union Medicale, 1872, p. 46.

There have also been reported a few other instances of recovery in very young infants after tracheotomy, but in none of them is it stated that the operation was for diphtheritic croup. It may be proper, however, to mention these in this connection for the purpose of including all the cases found of recovery under one year after tracheotomy, for whatever reason performed. Scoutteten's case ("Soc. Med. des Hop. de Paris," 1867), in his own child, six weeks old, was evidently one of spasmodic croup, in the radical treatment of which the father's fears overbalanced his judgment. Annandale (*Edin. Med. Jour.*, 1862, p. 112) reports a case in a child three months old. Impending suffocation appears to have been due to a retro-pharyngeal abscess. The child lived but seven weeks, and was wearing the tube at the time of death. Evidently

for the same disease Steinmeyer (*Berlin klin. Woch.*, 1880, No. 40, p. 572) performed the operation successfully on a child aged nine weeks. Mr. Croft had a similar result on a child aged six months (*Lancet*, 1880, p. 849) who was suffering from symptoms of edema of the glottis, associated with an erysipelatous inflammation and edema of the entire cervical region. No false membrane was found; neither did croupous cough exist. Mr. Lawson Tait, of Birmingham, mentions (*Brit. Med. Jour.*, April 15, 1871) a successful case at seven months, but no other particulars are given. The same is the case with another, aged nine months, in which he believes that the child was destroyed by its mother, who deliberately obstructed the tube, three weeks after the operation.

LOCAL ETHERISATION IN STRANGULATED HERNIA.—Dr. W. Finkelstein, of Jassy, describes his method of reducing strangulated hernia thus: "I lay the patient on his back, and make him draw up his knees. In inguinal hernia I support the scrotum on a pad or pillow, and pour one or two tablespoonfuls of ether over the integuments of the sac; I then lay over it a cloth folded three or four times. This I repeat every fifteen minutes. After the third or fourth repetition, the coils of intestine become mobile, and sometimes slip back of themselves into the abdomen. If they do not do so I attempt to reduce them gently; and in fifty-four cases out of fifty-eight I have succeeded. I find the treatment more successful the less time is previously spent in taxis; so I apply the ether as soon as possible after the strangulation. It is easy to see why. When the bowel has been nipped for some time, it becomes paralyzed and loses its power to contract and to conduct peristaltic movements. Thus your chance becomes less hopeful or is lost. I had no instance of simply omental hernia in these fifty-eight cases. I should think in such a case etherisation would be useless. In cases where the hernial coverings were much thickened it would probably be less effective." To lessen the burning pain produced by the ether, a mixture of 100 parts of sulphuric ether with 20 of oleum hyoscyami is used. The ether must be poured on, not dropped.—*Berl. klin. Woch.*—*Practitioner*.

CURE FOR EPITHELIOMA.—Dr. Wm. A. Collins (*Cin. Lancet and Clinic*) gives some cases where cure followed the application, thrice daily, of *fresh ergot freshly ground to an impalpable powder*. The pow-

der was applied dry, with a camel's-hair brush, and over all was placed a muslin cloth saturated with

R. Acid carbol.....	3i.
Acid surphurosi.....	3i.
Glycerine	3iv.
Aquae.....	3iiss. M.

The sore was washed once a day. Tonics, etc., were also administered as freely as required.

EXCISION OF CHANCRE.—At a meeting of the New York Academy of Medicine last month, Dr. P. A. Morrow read a paper on this subject (*Jour. Cutan. and Venereal Diseases*), in which he drew the following conclusions:

1st. The facts of clinical experience, as well as deductions from analogy and experiment, are opposed to the theory of the local nature of chancre, upon which the practice of excision is based.

2d. The practice of excision of the chancre, as a means of aborting syphilis, is condemned by its clinical results, when these results are weighed in the balance of discriminating judgment, due regard being had to the possibilities of error.

3d. These sources of error are comprehended under doubtful diagnosis, insufficient observation, both as regards time and method, and *post hoc* conclusions.

4th. In cases where secondary accidents fail to appear after excision, there is no positive evidence that it had an abortive influence, since experience proves that sores with all the typical signs of infecting chancre are sometimes not followed by constitutional syphilis.

5th. There is no evidence that excision of the chancre attenuates the syphilitic virus and modifies the intensity of general symptoms, since the benignity or malignancy of syphilis is a matter of individual constitution.

6th. It cannot be recommended as a local adjuvant, since it is opposed to the principles of sound surgery to remove, by an operation involving loss of tissue and an indelible cicatrix, an accident which always disappears by a process of spontaneous absorption, leaving, as a rule, no posthumous evidence of its existence.

AN APPARATUS FOR SECURING GOOD POSITION IN ALL OPERATIONS ON THE PERINEUM, THE BLADDER, THE VAGINA, OR THE RECTUM.—It had

been brought from London by Dr. T. A. Emmet, and consisted of two padded rings or bands to encircle the legs just below the knees. To one ring was attached a steel rod, to the other a barrel which received the rod. The rod could be secured at any point by means of a thumb-screw passing through the wall of the barrel, and thus permitted any degree of extension required (consequently, separation of the knees, and placing the perineum on the stretch). To the inside of one ring was attached a strap which was to pass around the patient's neck and be held fast with a buckle at the inner side of the opposite ring. With this strap the elevation of the limbs could be regulated. [A more complete description, with illustration, can be found in the "Medical Record" for December 9, 1882.]—*N. Y. Med. Jour.*

RELIQUET'S INJECTION FOR CHRONIC CYSTITIS. — According to "L'Union Medicale," this consists of crystallized phenic acid, dissolved, with the aid of a sufficient amount of alcohol, in from one thousand to two thousand parts of distilled water. Properly prepared, it is said to give rise to no pain, but to act as an astringent, modifying the denuded surfaces and hindering absorption. After having washed the bladder out with water of the temperature of the body, the solution is injected very slowly, until the bladder is well distended, so that the liquid comes in contact with every portion of its interior. The injection is then allowed to flow out, and the organ is again washed out with warm water.—*Ibid.*

LOCAL TREATMENT OF BURNS.—In the *Medical Record*, December 9th, will be found an article by Dr. Robert T. Morris, on the local treatment of burns. The results obtained by the method he employed were so good that it merits attention. The first step in his management of a case was to open all the blebs, remove all loosened cuticle and trim all ragged edges. Then iodoform was sprinkled thickly over the denuded surface. This application acted both as an antiseptic and analgesic. Strips of cheese-cloth were spread with vaseline and, sprinkled with iodoform, were then carefully applied to the wounded surface, care being taken to prevent any wrinkles being left to irritate the tender surface. Over this, there was laid sheet lint saturated with carbolized water. The whole dressing was then covered with an ordinary roller bandage. In a few days healing commenced and continued with great rapidity. The common plan of allowing blebs to remain and not to trim the loose pieces, Mr. Morris has shown by actual experiment to retard the healing process.—*Chicago Med. Review.*

OBSTETRICS.

A VAGINAL DOUCHE.—The hot douche as a therapeutic means in the treatment of uterine and vaginal disease is of recognized value. But outside of the hospital and among people of means its use is very limited. The apparatus which renders the taking of a hot vaginal douche a comparatively easy undertaking is quite expensive, thereby excluding it from a large class of patients. When we try to reach the same end by the use of pillows, rubber cloth, chairs, etc., our patient is generally overcome by the manifold directions, and if the attempt is made she is almost sure to saturate herself, the bed, and bedding, and the hot douche is ever after thought of only with disgust. Then with any apparatus an assistant can hardly be dispensed with.

The following simple contrivance I have found materially simplifies the matter, and renders the taking of the hot douche not such an appalling operation. The expense is practically nothing, an assistant can be dispensed with, and the preparations for taking the injection can be made in a moment. A blanket, chair, pail of hot water, syringe, wash-basin, and board (which I will now describe) constitute the necessary apparatus. The board is one-half inch thick, either pine or white-wood, ten inches long and ten inches wide; on the under side, and at opposite edges, on which two strips, two by twenty-four inches, are nailed, so that the whole looks not unlike a wash-board with long legs; uniting the two free ends of these strips is a short strip, which hooks over the front round in an ordinary kitchen chair, thus preventing any slipping. A cushion tacked on the board will increase the comfort of the patient; this should be covered with some rough cloth rather than anything smooth. The siphon syringe is the best, but by adding two feet of one-fourth inch rubber tubing to suction end of a Davidson's we get the same thing. A broom stick resting on the upper side rounds of the chair and tied to the front legs makes a very good rest for the feet.

The patient is to take a blanket and fold it lengthwise two or three times, and lay on the floor; two feet from one end of it is placed the chair, in which is a pail of hot water and syringe, and between is the board (described above). An earthen wash-bowl is placed at one side within easy reach. She is now to lay down with the nates well over the edge of the board; by raising herself on feet and shoulders the board can

easily be hooked on the round of the chair. Now slip the basin under the board and everything is in readiness for the injection. The ordinary wash-basin holds nearly one-half pail of water so by having two the necessity of interrupting the douche will be avoided.—J. B. GEROULD, M. D., *Boston Med. and Sur. Jour.*

PUERPERAL DIABETES.—A paper on this subject was read by Dr. Matthews Duncan, at a late meeting of the London Obstetric Society. The author pointed out the distinction between the slight glycosuria of pregnant and suckling women and real diabetes, with its polyuria and large amounts of sugar. Physicians and surgeons were well aware of the dangers introduced into their case by complication with diabetes. But the subject of diabetes complicating pregnancy and parturition had attracted almost no attention; and this probably arose from its rarity, which might be accounted for by the disease frequently destroying in women the sexual energies, as it is said to do in man. The author had collected twenty-two cases in fifteen women, and they demonstrated the great gravity of the complication as respects both mother and child. Of the twenty-two pregnancies (including those ending prematurely), four had a fatal result soon after delivery. In seven of nineteen pregnancies in fourteen women, the child, after reaching a viable age, died during pregnancy; in two the child was born feeble and died in a few hours—making an unsuccessful issue in nine of nineteen pregnancies. The histories showed that diabetes may supervene on pregnancy; that it may occur only during pregnancy, being absent at other times: that it may cease with the cessation of pregnancy: that it may come on after parturition; that it may not come on in a pregnancy occurring after its cure. They showed that pregnancy may occur in a diabetic woman; that it may be not appreciably affected in its natural progress and termination by the disease, and that it is very liable to be interrupted by death of the fetus.

Dr. Robert Barnes had investigated the condition of the urine in pregnancy, as to albumen, urea, and sugar. The occurrence of sugar was physiological, though not constant. Sinety had shown that sugar appeared in the urine when lactation was suppressed; this was of interest in connection with the normal fatty change in the liver shown by Tarnier to occur in pregnancy. He (Dr. Barnes) drew a parallel between albuminuria and glycosuria during pregnancy. Both were physiological, but might pass the physiological boundary, and then grave accidents ensued.—*Louisville Med. News.*

THE EFFECTS OF OIL OF TANSY.—Dr. G. Jewett (*Boston Med. and Surg. Jour.*) reports eight cases of poisoning with this drug. Case 1: Fifteen drops at 11 A. M., teaspoonful at 2 P. M.: Convulsions, shock, general cyanosis; recovery. Case 2: Teaspoonful to promote catamenia: convulsions and death in one hour and a half. Case 3: Unknown quantity to cause abortion: convulsions; death in three hours and a quarter; no abortion. Case 4: Teaspoonful to cause abortion; coma, recovery; no abortion. Case 5: Four drachms; spasms and death. Case 6: To cause abortion; rapid death; no abortion. Case 7: Decoction of tansy-leaves to produce abortion; paralysis; coma; death in twenty-four hours without abortion. Case 8: Infusion of leaves daily for a week; also for vaginal injection; abortion, metritis, peritonitis; recovery after three months. As druggists are often asked for oil of tansy under various pretenses we believe the above table will be useful in reminding them of the dangers attending the sale of tansy and its preparations.—*Louisville Medical News*.

DEATH FROM OIL OF TANSY.—A servant girl in Trenton, N. J., recently died from a dose of oil of tansy, taken probably to produce abortion. Post-mortem examination showed that she was not pregnant.—*Chicago Med. Review*.

ATROPIA IN HYSTERIA.—Dr. H. Leaman (*Med. Bulletin*) after using atropia hypodermically to relieve and prevent hysteria, speaks in the highest terms of his success.

From the stomach of a idiotic girl, aged 10, who died in the Lancaster Asylum, there was removed a mass of vegetable fibres, (straw, twigs, fragments of matting, thread, &c.,) so interwoven and moulded as to make a cast of the stomach and duodenum. The stomach was 18 inches in length, and weighed 31 ounces. The case is interesting as showing how, in an individual of low nervous organization, obstruction of the stomach by a gradually increasing mass, might for a long time be tolerated without any obvious symptoms of irritation.—*Brit. Med. Jour.*

REVIEWS AND BOOK NOTICES.

Prices are always inserted when furnished by the publisher, or when obtainable from the bookseller.

How Can we Obtain and Preserve the Best Eyesight and Hearing? A Paper read before the Sanitary Convention at Greenville, April 11, 1882. By Leartus Connor, A. M., M. D., of Detroit, Mich.

This paper is extracted from the report of the Michigan State Board of Health, and is designed for popular reading. The author writes plainly and sensibly, and answers his own question as follows:

(1.) By acting as if the eyesight and hearing were of more importance than any other thing on earth.

(2.) By having every child's eyes and ears carefully examined by an expert before it is given specific tasks to perform calling for the full exercise of healthy eyes. If the eye or ear be found defective, then by grading the tasks according to the nature of the defect.

(3.) By never using the eye or the ear when such use causes pain in either organ or in the head.

(4.) By never using the eye when it is imperfectly supplied with good blood, as before breakfast, when utterly exhausted, after a severe illness, etc.

(5.) By never using the eyes for close work in an imperfect light, as in early morning or evening twilight, by a very distant and weak light, far from the window on a dark day, etc.

(6.) By utterly avoiding the use of tobacco and alcohol, except for medicinal purposes.

(7.) By always cherishing a cheerful habit of thought and feeling towards all persons and all events.

(8.) By avoiding all such injuries to the ears as result from slapping, pulling, and very loud and sudden noises.

(9.) By keeping out of the external ear all things smaller than the forefinger, or stiffer than a towel or handkerchief.

(10.) By keeping out of the ear all oils, all soaps, all cold water, and everything else recommended by sympathizing but mistaken friends; especially never apply a poultice to the ear for the relief of pain. Dry heat will do all that moist heat can to relieve, and be free from the danger of absolutely destroying the membrana tympani.

(11.) All running ears must be cured at the earliest possible moment, at the peril not only of the hearing but that also of the life.

(12.) By heeding the warning given by redness of the eyelids and of the white of the eye, by pain in or about the eyes or ears, by the continu-

ance of indistinct vision for any considerable time, or of imperfect hearing, by the continuance of a frontal headache after usual remedies have failed to relieve it.

(13.) By regarding the eyes and ears as simply a part of a very complex system of apparatuses, the best health of all being absolutely needful for the best health of each.

(14.) By remembering that we do not see with the eye or hear with the ear but with the brain. Hence after the brain is exhausted it is impossible to really see or hear. Hence the utter absurdity as well as perniciousness of any endeavor to see or hear after the brain has become exhausted. Especially is this true of young and growing brains. Here, too, it is needful to remember that the normal brain continues to grow until about the age of forty.

Essentials of Vaccination: A Compilation of Facts relating to Vaccine Inoculation and its Influence in the Prevention of Small-Pox. By W. A. Hardaway, M. D., Professor of Diseases of the Skin, etc. Chicago: Jansen, McClurg & Co. 1882. Pp. 146. Cloth, \$1.00.

In this small volume Dr. Hardaway has given us all that is essential to be known with reference to vaccination and its protective power against variola. The history of vaccination, of variola in animals, and of vaccinia is concisely given, the abnormal modifications and complications of vaccinia are alluded to, and the importance of revaccination dwelt upon.

As to the latter, the author says: "From my own experience * * * and in view of the general inefficiency of vaccination, and especially from the fact that individuals undoubtedly vary as to the immunity granted by vaccinia, I should say that under danger of infection revaccination should be performed, even if a few months only had elapsed from the date of the previous inoculation; and, moreover, I am constrained to agree with Trousseau, who recommends that vaccination be repeated as often as once in every five years; for if this practice be unnecessary, it is, at all events, free from objection. Finally * * * an adult revaccinated with animal lymph will be as fully protected against small-pox for the rest of life as 'if he or she had twice had that disease.'" (Martin.)

The author considers the merits and demerits of humanized and bovine virus, and strongly prefers the latter, as being incapable of transmitting any other disease, as certain to "take" when skilfully employed, and as affording more perfect protection. The methods of procuring and storing virus are clearly given, and the operation of vaccinating plainly described. The objections to vaccination are fairly met and refuted.

We recommend this little work as one needed by every physician who expects to vaccinate.

G. A. C.

The Therapeutic Action of Potassium Chlorate. By John V. Shoemaker, A. M., M. D., Philadelphia, Pa. Reprint from Transactions of the American Medical Association.

This monograph reads like a patent medicine almanac. The author either "cures" or "greatly benefits," pretty much every disease in the catalogue by his one *cure-all*; or at least he thinks he does, which thought gives him pleasure and his patients confidence.

He speaks—to select at random—of the use of this drug in anemia, and says: "If good food, exercise, and pure air be given conjoined with and after the medicinal action of this salt, the anemia will, in many, rapidly tend to a permanent cure." Exactly; and "good food, exercise, and pure air," conjoined with drop doses of aqua pura, the thirtieth dilution of chalk, or any other placebo, "will, in many, rapidly tend to a permanent cure."

If Dr. S. will read Forbes' "Homeopathy, Allopathy, and Young Physic," or Harvey's "First Lines of Therapeutics," or Jennings' "On Medical Reform," or even old Hahnemann's "Organon," he will, perhaps, not be so sure that there was any connection between his "happy results" and the chlorate.

Chlorate of potash in moderate doses is a very fair placebo, having a slight effect locally on the mucous membranes. In large doses it is an irritant locally, and frequently does mischief, while it is more than questionable whether it does not permanently injure the kidneys during its excretion.

The Physician Himself, and what he should add to his Scientific Acquirements. By D. W. Cathell, M. D., Late Professor of Pathology, College Physicians and Surgeons, etc., Baltimore, Maryland. The Second Edition. Published by Cushing & Bailey, Baltimore, Maryland. Price, \$1.25.

We congratulate Dr. Cathell that the extensive sale of his work has so soon rendered a second edition necessary. The work has been rearranged, enlarged, and divided into chapters, while the index which has been added increases its value very materially. No one can read this book without getting many useful hints, which may, in the end, bring in many hundred times the original cost of the book. It is particularly suited to those who are about to start in practice, as they will here learn much that they would otherwise be years in learning, and which many would never acquire at all. It is a book to develop "*tact*," that *sine qua non* of eminent success in any calling, but especially in ours.

The Diseases of Women, Their Pathology, Diagnosis and Treatment, including the Diagnosis of Pregnancy. By Graily Hewitt, M. D., Lond., F. R. C. P., Professor of Midwifery and Diseases of Women, University College, etc. Fourth American, from the third revised and enlarged London edition. With one hundred and thirty-two illustrations. Philadelphia: P. Blakiston, Son & Co. 1882. Sold in Columbus, O., by A. H. Smythe. 8vo. Pp. 751. Paper, \$1.50, Cloth, \$2.50.

This has been a standard work for many years, and those familiar with its contents will need no inducements to procure it. The theories of pathology and treatment are largely personal with the author, who is the exponent of what he calls the "mechanical" system of uterine pathology. He draws largely for his statistics on the records of the University College Hospital, with which he was connected for many years, and has no difficulty in harmonizing his facts with his theories. Dr. Hewitt is especially happy in diagnosis, and his chapter on the Diagnosis of Pregnancy is unusually satisfactory.

The present edition appears to be a reprint of the third American edition and of the third London edition of 1872. In our judgment the value would be materially increased by revising it to the present date.

The typographical appearance is excellent, and the book in its present form is a marvel of cheapness. G. A. C.

Procidentia, and its Relief. With a case. By E. E. Montgomery, M. D., Obstetrician to the Philadelphia Hospital. [Reprinted from Transactions of the Pennsylvania State Medical Society.]

After a pleasant description of the diseased condition, its causes, etc., the author proceeds to consider its treatment. Pessaries answer a temporary purpose only. Radical treatment must renew the vaginal support, and for this he recommends the operation of Le Fort, as modified by Tracy. Le Fort draws down the uterus, has it retained by a tenaculum or vulsella, and removes a section of mucous membrane from the anterior wall 4-5 of an inch wide, beginning near the os and extending to near the vulva, about $2\frac{1}{2}$ inches long. A similar section is removed from the posterior wall, and the edges brought together so that the freshened surfaces may be in apposition. The sutures are introduced alternately on either side, beginning with those nearest the os, and the uterus is pushed up as they are introduced. He used silk, and as the removal would be attended with difficulty, they were allowed to rot out. This operation forms a double vagina. Tracy modified the operation by restoring the perineum.

The Antiseptic Treatment of Wounds, after Operations and Injuries By W. T. Briggs, M. D., Professor of Surgery, Medical Departments of University of Nashville and Vanderbilt University.

This is a re-print from the *Nashville Journal of Medicine and Surgery*. The writer endeavors to sustain the following propositions :

- 1st. The germ theory of wound infection is not established.
- 2d. The antiseptic treatment of wounds after operations and injuries, is not limited to Listerism nor to any other special method, but is based upon broad, general principles.
- 3d. Antiseptic surgery embraces every condition or agent that tends to prevent putrefactive changes in wounds, or to remove or neutralize the effects of such changes when they have occurred.
- 4th All wounds are healed by reparative inflammation.
- 5th. All wound accidents are the result, either directly or indirectly, of destructive inflammation.
- 6th. The antiseptic treatment of wounds, properly considered, consists first, of such means as will restrain inflammatory action within reparative bounds; and second, of such means as will subdue excessive action and remove or neutralize the effects of destructive inflammation.

Medical Electricity: A practical treatise on the Application of Electricity to Medicine and Surgery. By Roberts Bartholow, M. D., LL. D., Prof. of Mat. Med. and Ther. Jefferson Medical College, Philadelphia, etc., etc. Second Edition, enlarged and improved. 109 illustrations. Philadelphia: Henry C. Lea's Son & Co. 1882. Columbus: Geo. W. Gleason. 8vo. Pp. 291.

It is very evident that Dr. Bartholow was correct in his view that the profession desired a small, plain, and complete work on the practical uses of electricity. It is only about a year since the first edition of his book appeared. In preparing the second edition he has enlarged the book somewhat, and has added some new matter, but not much. In truth, the work was so complete, for its purpose, as it first appeared, that no considerable alterations or additions would be possible. Every physician who owns a battery should possess and study this book.

Transactions of the Medical Association of the State of Missouri, at its twenty-fourth Annual Session held at Mexico, Missouri, May 17, 18 and 19, 1881.

This contains the minutes and papers read at the meeting, and a full stenographic report of the discussions. This latter idea we should be pleased to see adopted by all State Societies, subject to the revision of the Publication Committee.

G. A. C.

Slight Ailments; Their Nature and Treatment. By Lionel S. Beale, M. D., F. R. S., Professor of the Principles and Practice of Medicine in King's College, London, etc. Second Edition, Enlarged and Illustrated. Cloth, pp. 283. Price, \$1.25. Philadelphia: P. Blakiston, Son & Co. 1882.

This volume may be very properly regarded as quite an important contribution to medical literature. It does not treat of the graver forms of disease, to be sure, but it considers those conditions of the system which may be the forerunners of more formidable affections, and which may be cut short by early treatment.

As prevention of disease is the great desideratum in practice, the idea of the book is a good one, and it occupies a field not exactly filled by any other work with which we are familiar.

Medical Relations of the Prevailing Forms of Food Adulterations. By Henry Leffman, M. D., Lecturer on Toxicology at Jefferson Medical College, Philadelphia. Reprinted from Transactions of Pennsylvania State Medical Society.

The author does not find much, if any, harmful adulteration. He finds glucose and oleomargarine harmless, though the latter may become a source of danger if made of improper material; but the same may be said of butter. Starch, plaster, chalk, and other matters are used to some extent, but never so as to become dangerous. The buyer is simply defrauded; injured financially, not physiologically. No account is taken of the moral injury done the manufacturer of the adulterated articles.

The Treatment of Syphilis with Subcutaneous Sublimate Injections. By John V. Shoemaker, A. M., M. D., Physician to the American Hospital for Skin Diseases, etc. Reprint from *Transactions of the American Medical Association*.

After a careful reading of this paper we fail to see any particular advantages possessed by this method. To be sure, the physician who gives a patient a hypodermic injection daily may seem to be "doing something" (see Cathell), but aside from that this method seems to have no particular *raison d'être*, except in those rare instances where the stomach will not tolerate the mercurial in any form.

Transactions of the Medical Association of Georgia. Thirty-second Annual Session, 1881.

These transactions appear neatly bound in cloth, and although delayed by unavoidable difficulties, present a very readable
I.-7.-6.

table of contents. We refer with satisfaction to the papers entitled "Uses of the Fluid Extract of Ergot," "Report of two Cases of (Abdominal) Surgery," "Gun-shot Wound of Abdomen," and "Tar-Water as an anti-septic." The Reports on Necrology and Biography are particularly full and interesting. We regret to learn that so small a proportion of the profession of Georgia are members of the Association, and would recommend all to join a Society which, notwithstanding its disadvantages, has a vigorous vitality.

G. A. C.

Nitro-Glycerine as a Remedy for Angina Pectoris. By William Murrell, M. D., M. R. C. P., Lecturer on Materia Medica, etc., at Westminster Hospital, etc. Detroit, Mich. George S. Davis, Publisher. 1882. 12mo. Pp. 78. \$1.25.

Dr. William Murrell gives in this little book some interesting cases of Angina Pectoris, in which he used nitro-glycerine as a remedy, with marked success, and no injurious results. Like many in the medical profession, he has not hesitated to try its effects on himself. The book contains many practical suggestions.

The Oleates and Oleo-Palmitates in Skin Diseases. By John V. Shoemaker, A. M., M. D., of Philadelphia, Pa., Physician-in-charge of the American Hospital for Skin Diseases, etc. *Transactions of the Pennsylvania State Medical Society.*

This is a very fair paper, in which the author gives his experience with the various oleates, especially in skin diseases. The author's fondness for drugging is well known, and his faith in the efficacy of his medicines is truly refreshing—in this day of doubting Thomases, but until he adopts the *numerical method* his conclusions must be accepted *cum grano salis*.

Some Points on the Administration of Anesthetics. By George H. Rohe, M. D., Professor of Hygiene and Clinical Dermatology, College of Physicians and Surgeons, Baltimore.

The author prefers ether to chloroform, as an anesthetic for general use. His paper gives a brief *resume* of the indications of danger, and the methods of meeting them. He gives Warren, of Boston, credit for first using ether. We are surprised at this, as, being a Southerner, we should suppose he would support the claims of Long, of Georgia, who used ether first March 30, 1842, while Warren did not use it until October 17, 1846.

Index Catalogue of the Library of the Surgeon General's Office, U. S. Army. Authors and Subjects. Vol. III. Washington, Government Printing Office. 1872.

The third volume of this massive and incomparable work of reference, though containing over a thousand quarto pages, in double columns and fine print, covers but from the word *cholecystism* to *dzondi*. One may judge of the extent of the library and the fertility of the index by the fact that the single word "*cholera*" occupies 151 pages with an average of more than 100 references to a page. To have access to a library such as the "*Index*" refers to is almost sufficient to cause one to regret not being a resident of that city.

Six Lectures on Light. By Prof. John Tyndall. (Illustrated.) Price 15 cents. J. Fitzgerald & Co., Publishers, 30 Lafayette Place, New York.

As a popular expositor of science, Professor Tyndall holds the very first place. In the work named above, a subject of no little difficulty and abstruseness is treated by him in a style which for clearness of expression and grace of diction challenges our admiration. The work forms a valuable addition to the excellent series of popular scientific books known as the Humboldt Library of Science.

James Vick.—From the appearance of *Vick's Floral Guide*, which is on our desk, we should judge that the young Vicks are "chips of the old block," as the *Floral Guide* with its lithographed cover is handsome enough for the parlor table. It is printed on the best of paper, has three colored plates of Flowers and Vegetables, and full of useful information. Those who send 10 cents for it can not be disappointed, as the plates alone are worth the amount. Address, as in past years, JAMES VICK, Rochester, N. Y.

The Washington World and Citizen-Soldier, the Old Soldiers' Paper, the People's Paper, is now in its eighth year, enlarged to 48 columns, 8 pages, in entire new dress, every week, at only One Dollar a year. Specimen copy free to any address, on receipt of postal card request, by the World and Soldier Publishing Company, World Building, 1006 F St., Washington, D. C.

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OLEIC ACID AND THE OLEATES.—Oleic acid is a product of the manufacture of stearine candles. It has the consistency of a thin oil, has the color of pale sherry wine, a faint, peculiar odor and taste, specific gravity, .900, combining weight, 282. When applied to the skin, it wets it like water, and is almost immediately absorbed.

The oleates of the alkaloids are made by rubbing the alkaloid (not the salt) to a powder in a mortar, and then adding the acid, with trituration, until it is dissolved, when the solution should be poured into a bottle, the mortar and pestle rinsed with fresh acid into the bottle, and enough acid added to make the desired percentage. Oleates should be freshly made. As they are seldom used of full strength, they should be diluted with oleic acid. They are for external use only, although the oleate of quinia may be available for hypodermic use. On being applied to the skin, the surface should be covered with oiled silk or rubber tissue. Absorption is usually complete in half an hour.

Oleate of Aconitia. This has a strength of two per cent. The aconitia used should be that precipitated from Duquesnel's "aconitia," which is a nitrate containing about 80 per cent. of the aconitia. Other aconitias can be used, but they are inferior and not to be recommended. This oleate costs about a cent a grain, but as a single drop makes a dose it is not

particularly expensive. It is especially recommended in neuralgia of the fifth nerve, being applied over the points of emergence, or directly over the painful spots. It should be spread over the surface with the end of the cork.

Oleate of Atropia. Of two per cent. strength. Should be used as an application to painful joints, or wherever a belladonna plaster would be applicable. A drop or two would be sufficient for a single application.

Oleate of Morphia. Of five per cent. strength. This is especially valuable in the case of infants and children, as five or ten drops can be easily applied to the inside of the thighs or the abdomen. Each drop contains about one-twentieth of a grain of morphia.

Oleate of Quinia. Of twenty-five per cent. strength. Can be used where it is important to save the stomach. As one or two fluidrachms constitute the dose, and as this is too much to apply directly to the skin without its running, it is advised to use pieces of old muslin, six or eight inches square. Such pieces will take up half a drachm of the oleate and can then be applied to the abdomen and inside of the thighs, under oiled silk. As absorption takes place, fresh oleate can be added.

Oleate of Strychnia. Of two per cent. strength. Each drop represents about one one-hundredth of a grain of the alkaloid. It would seem to be indicated wherever the local effect is desired, as in the treatment of some forms of eye diseases, and of local paralyses.

Oleate of Veratria. Of ten per cent. strength. This has the same indications as the oleate of aconitia, and is to be used in the same way.

These oleates of the alkaloids are all fluids and should be, as their application demands an accuracy of dose easily attained by minims or drops, but not so easily attained if they were semi-solids; but the oleates with metallic bases do not need such accuracy of dose, and are best dispensed and applied as soft ointments.

Oleate of Mercury. Of twenty per cent. strength. Is made by putting the yellow oxide and the acid together *in the cold*, and waiting until solution takes place, stirring occasionally. It is a soft solid, like very soft butter. This oleate is the best known of all, and its uses and applications too generally known to need repetition here. Suffice it to say that by its epidermic use the most prompt, the best, and the most easily controlled mercurial impression can be obtained, whereby a remedy often dangerous is rendered, under proper skill and care, comparatively harmless or alto-

gether beneficent in a very large number of cases which cannot be very successfully treated without mercurials. This oleate can be diluted with olive oil, or better with oleic acid.

Several other oleates have been mentioned as available for medicinal uses, and possibly some of them may be found useful, but as yet there is no accumulation of testimony in regard to them.

We are indebted to Dr. Squibb's *Ephemeris* for the facts upon which we have based this article.

THE W. VA. BOARD OF HEALTH.—The Governor of West Virginia takes occasion to pay a well-deserved compliment to the State Board of Health, in his annual message. Indeed, this Board is getting compliments from all quarters. It seems probable that the excellent law under which it works will be adopted by several States during the present winter. It is so perfect that the Board is unable to suggest any alterations which it desires, and both the people and the medical profession seem to be entirely pleased with it and the manner of its execution.

At a recent meeting of the Board, Hon. A. R. Barbee, M. D., offered the following preambles and resolution, which were adopted :

WHEREAS, This Board has received many very high compliments from distinguished sources for the manner in which it has performed its difficult labors—notably, for its efforts to elevate the standard of medical education in West Virginia; and,

WHEREAS, It is always just and proper to acknowledge credit to whom credit is due; therefore,

Resolved, That this Board is fully sensible of the eminent services of its Secretary, Dr. James E. Reeves, to whom belongs in the main the credit of directing its successful labors, and in all things upholding its good name, by his faithful energies and labors alike for the State and the medical profession.

SCHMIDT VS. THE BACILLUS.—The long-looked for and much-announced paper by Schmidt, of New Orleans, in which he was to show that Koch did not know the difference between a bacillus and a fat crystal, has at last arrived, being the leading article in the December issue of the *Chicago Medical Journal and Examiner*.

After a careful reading of the paper, we are obliged to confess that Dr. S. has most signally failed in his attempted demonstration. He figures plenty of fat crystals, about whose identity there can be no manner of question, but he nowhere shows that these are what Koch and others have called *bacilli*. Bacilli are entirely different in size and shape from these

crystals, while their response to color tests is equally conclusive of their lack of identity.

The existence of this bacillus cannot be denied; but there is abundant opportunity for investigation into its pathological significance.

It is in Massachusetts this time, aye, even in Boston itself, that there has been found a veritable, Simon-pure, diploma mill. No study is required, no lectures (not even for three weeks), nothing but the fees and a thesis.

Moreover, the law is such that this institution, which calls itself the "Bellevue Medical College," has a legal existence and its diploma-holders are legal doctors. The Illinois Board of Health discovered this fraud, and thus added another link to the chain of evidence showing the importance, the *necessity* rather, of such organizations.

THE NEW YORK Post-Graduate Medical School has thus far met with gratifying success. The second term opens January 8, 1883, and continues, without intermission, until April 28th. It is hoped that, with its improved facilities for instruction and increased corps of teachers, it will meet with still greater success.

DR. FORMAD, of Philadelphia, has produced epithelioma in dogs by incising the skin and keeping up the irritation with a weak croton oil—croton oil mixed with glycerine. It is said that under the microscope this artificial product does not vary from the epithelioma in man. He also produced sarcoma in the bones of dogs by fracturing them and keeping up irritation by motion.

THE PLEXIMETER "must go." A Cincinnati doctor has discovered that when his finger is used to receive the blow of the plexor, the sensation produced upon it is painful in percussion over a dull spot, but not over a resonant area. His finger is not for sale.

UNITED STATES DISPENSATORY.—During the present month the fifteenth edition of the United States Dispensatory will be completed. The editors are Dr. H. C. Wood, Prof. J. P. Remington, and Prof. S. P. Sadtler. The revision has occupied about three years, and embodies the most recent discoveries in materia medica, pharmacy, chemistry and therapeutics. This is a revival of an old and famous work. The rela-

tion of the work to the United States Pharmacopeia will be maintained, but the Dispensatory will be encyclopedic in character, and will contain in addition to the list, official drugs and preparations, not only those being out of date, but a careful consideration of the most recent non-official drugs. The work is published by J. B. Lippincott & Co.

JOURNALISTIC CHANGES:—*Canadian Journal of Medical Sciences* has changed its name to *Canadian Practitioner*. The change is a wise one.

THE *Louisville Medical News*, our old favorite, comes to us in a new dress, and has increased to 16 pages each week.

THE *Annals of Anatomy and Surgery* is henceforth to be independent. It is a most excellent journal, and, as the only publication specially devoted to surgery, should be taken by all surgeons. Its prospectus for this year presents an admirable list of contributors. Its matter is all original, and its editorials are particularly strong.

The Medical Age is the name of a journal supposed to be the result of a union of the *Michigan Medical News* and the *Detroit Clinic*. It is very easy to demonstrate the *News* element in the compound, but it will require a careful spectroscopic examination to detect any evidences of the *Clinic*.

THE *St. Louis Clinical Record*, the *Arkansas Doctor* (thank heaven!), and the *Archives of Dermatology*, are dead.

THE *N. Y. Medical Journal* has become a weekly, as has also the *Sanitarian*, of the same city. Both journals are much improved by the change, and both were already very excellent.

CASE OF TRAUMATIC RECTO-VESICAL FISTULA.—Dr. W. M. Bemus, of Jamestown, N. Y., reports to us briefly an interesting case of injury to the rectum and bladder. The patient, aged 25 years, fell from about twenty feet, striking upon a sharp stub, about two inches in diameter, which penetrated the rectum for six inches and entered the bladder above the prostate. Urine passed freely from the anus after the withdrawal of the stick. Treatment consisted of anodynes as needed, hot fomentations, and the retention in the urethra of a flexible catheter. At the date of the report, six weeks after the injury, the patient was apparently as well as ever, with no evidence of a recto-vesical fistula, and no pain in urinating or at stool.

OBITUARY.

Resolutions adopted by the Cuyahoga County Medical Society.—

WHEREAS, Dr. Benjamin Sheldon, honorary member of this Society, has recently been removed from us by death, therefore,

Resolved, That in his departure the profession have lost from their number a physician skilled in his profession, of great practical experience, extremely humble and modest in demeanor, of remarkable integrity, and strong sympathy.

Resolved, That during his thirty-six years of practice in this city, the sensitiveness with which he has regarded the rights of his fellow practitioners, and the constancy and liberality with which he has rendered service to the suffering poor, have given evidence alike of his devotion to the profession and the claims of humanity.

Resolved, That a copy of these resolutions be entered on the records of this Society, and also sent to the COLUMBUS MEDICAL JOURNAL with request for publication.

C. F. DALTON,
E. CUSHING,
M. L. BROOKS, } Committee.

CHAS. HINTZELMANN, M. D., *Rec. Sec.*

NOTES AND COMMENTS.

FLEXIBLE ANATOMICAL PREPARATIONS.—Dr. Roswell Park publishes his method in the *Annals of Anatomy and Surgery*. Omitting experimental details, the following are his procedures. The joints to be prepared—or any other parts selected for preparation—should be carefully dissected, by aid of maceration, so as to remove thoroughly all the soft parts except the ligaments. If one desire to use special care, the preparation may be soaked a few days in benzine to dissolve out the fat. It may then be bleached by hypochlorous acid in the following way: A small quantity—one drachm—of powdered potassium chlorate is put in a stone jar, and five and a half drachms of strong hydrochloric acid poured into it. The jar is then filled with water, and the specimens dropped into it. From

six to thirty hours in this solution suffice. After still further scraping and cleaning they are finally placed in the following mixture: coffee sugar, 2 parts: saltpetre, 1 part; methylic alcohol, 1 part; glycerine, 16 parts. A little water may be used to assist in the solution of the solids; or a good article of syrup may be substituted for the sugar. A little thymol may also be added with advantage, although it is not necessary. It should be dissolved in the methylic alcohol. In this mixture the specimens are allowed to remain from one to two, or even three, weeks, according to their size. After their removal from it, they are allowed to drain a few days, and then need only a little trimming and scraping before being placed in the cabinet. In most cases it will be well to scrape off all the periosteum, except where it would interfere with the ligaments. Under this treatment, the ligamentous structures becomes as flexible as they were during life, while thick tendons become almost transparent, and they remain so. Joints thus prepared with their capsules properly dissected make beautiful preparations. Instead of losing mobility, they become even more limber with time. He has made in this way a full series of preparations of joints of the body, over a year ago, and they are now better in every respect than when first made, save that they have darkened a little from their original bleached condition. There is not the slightest odor of decomposition about them. Subsequent trials and experiments have convinced him that his method may be successfully applied to all portions of the body, and specimens of any kind. Preparations of an entire limb may be made in this way, which shall be perfectly flexible, and serve the purposes of demonstration much better than the dried and varnished specimens found in our museums. In making them, the vessels should, of course, be injected first, preferably with a mixture of gelatine and glycerine, used warm. By this method there will be very little shrinking and shriveling up of the structure. Pathological specimens, of joints especially, can be in this way kept to show to the best advantage.

A PLEA FOR SPECIALISM.—“Our specialistic friends who have departed from out of the University of New York, have done a brave and spirited act. They have struck a much-needed blow in behalf of specialism. Whatever may be the reasons assigned publicly, the real cause underlying the whole affair is to be found in the aversion of faculties to fully recognize specialists. It is always tacitly assumed that the man who treats twenty-eight feet of alimentary canal is better than he who merely looks

after the interests of eighteen inches of spinal cord; or those who ply typhoid fever patients with drugs until the disease has doggedly run its course, or those who are learnedly at hand to welcome infants whom the uterine muscles are intelligently propelling into the world, are doing more scientific and important work than those whose skill opens a new world of sight and opportunity to a myope, or arrest an approaching amaurosis, or than those who turn back a mental disease or act as precise interpreters of the meaning of the dread symptoms of cerebro-spinal maladies. In other words, he who is most familiar with the special senses and the most important viscera—the brain and the cord—is relegated to a position inferior to the expert of an abdominal or thoracic viscus; thus blindly holding to tradition, the average ruling faculty refuses to do what business men in every walk of life are doing—reward superior knowledge and skill. It is a curious contradiction that in republican America the monarchical medical college faculty should thrive, wherein the government consists of a few grandees, whose indiscreet and superfluous boast it is that they are in no sense specialists, whilst in despotic and bayonet-ridden Europe the Universities are so republican that a tutor's vote is as weighty as a professor's. It is a rank and manifest injustice that this should be so in this country of democracy. For the continuance of such a tyranny of caste, no reason can be assigned that will not look hideous in the light of day. Time will right it, and before long. We hail then the first rebels!"—*Amer. Jour. of Neurology and Psychiatry.*

BEFORE HIS TIME.—A medical man, practicing in Dantzic, recently undertook the resection of the lung of a young female patient, with the consent of her parents. The *St. Petersburger Medicinische Wochenschrift* understands that, through the denunciation of two colleagues, the case, which ended fatally, will be made the subject of judicial inquiry; all parties, however, appear to admit that the attempt of the surgeon was made in perfect good faith, and in the full belief that it gave the patient a chance of recovery from otherwise incurable lung disease. Was the surgeon's conduct simply foolhardy and entirely reprehensible, or was he, on the other hand, before his time? It is by no means impossible, judging from analogies that abound in scientific literature and biography, that works may appear, one century hence, treating of resection of the entire lung as a recognized operation, and recording how, in the nineteenth century, the first pneumotomist got into trouble. Some, though not the majority of innovators, live to see their views and their practices established. In any case, full inquiry and fuller details of the Dantzic operation are imperatively demanded.—*Brit. Med. Jour.*

A MODERN FABLE.—“There were once four flies, and, as it happened they were all hungry one morning. The first settled upon a sausage, of singularly appetizing appearance, and made a hearty meal. But he speedily died of intestinal inflammation, for the sausage was adulterated with aniline. The second fly breakfasted upon flour, and forthwith succumbed to contraction of the stomach owing to the inordinate quantity of alum with which the flour had been adulterated. The third fly was slaking his thirst with the contents of the milk jug, when violent cramps convulsed his frame, and he soon gave up the ghost, a victim of chalk adulteration. Seeing this, the fourth fly, muttering to himself, ‘The sooner it’s over, the sooner to sleep,’ alighted upon a moistened sheet of paper exhibiting the counterfeit presentment of a death’s head, and the inscription, ‘Fly poison.’ Applying the tip of his proboscis to this device, the fourth fly drank to his heart’s content, growing more vigorous and cheerful at every mouthful, although expectant of his end. But he did not die. On the contrary, he thrived and waxed fat. For the fly-paper was adulterated.”—*From the Ger.—San Francisco Western Lan.*

INTERESTING AND INSTRUCTIVE DISSECTION, A FEW HOURS BEFORE DEATH, IN A CASE OF CANCER OF THE STOMACH.—A woman in Louisville, Ky., had cancer of the stomach, and it becoming apparent that life could not much longer be prolonged, Dr. Koehler, of Louisville, made a long incision in her belly, when he “had the pleasure” of seeing the tumor before him; thus confirming his diagnosis. The stomach, or so much of it as was involved in the tumor, was cut out, the vessels tied, and the wound in the stomach was closed by about forty sutures. The examination occupied an hour, a large portion of which time was consumed in the application of the sutures; a piece of painstaking which would seem to have had no other purpose than to render the post-mortem appearance of the body more agreeable to her friends. Perhaps she had no friends; but in case one has, we would suggest that hereafter, in making such *ante-mortem* examination, the sutures be omitted, since the long time required for their introduction always renders it possible that death may take place before the study is completed, and the surgeon might then rest under the unpleasant suspicion of having killed his patient. Fortunately in this case the patient lived five hours and a half, and without doubt, therefore, she died of cancer of the stomach; nor was her death in any way accelerated by the examination.

We take pride in saying that this is the first scientific observation of

this kind ever made in this country, and we congratulate the surgeon on its pleasant and satisfactory result.

In the light of the discoveries made by the dissection, it now seems quite probable that, had the woman not died a few hours later, she might have lived.—*Med. Gazette*.

SUBSEQUENT HISTORY OF NERVE-STRETCHING.—Dr. L. C. Gray forwards the following very candid note for publication :

“In my recent article on Stretching of the Facial Nerve, in the September number of *The Proceedings*, my second case, the young man of 22 years, was reported as cured. Since the publication of my paper, this patient, I regret to say, has relapsed. The relief was only obtained for two months and a half. Whether this present condition is as bad as it was when he first came to me, I have no means of knowing, for I have not seen him since the first day of the relapse.

“I hope this addendum will travel co-extensively with my article and correct it. I have always suspected, and have frequently stated my suspicion, that a very material difference would be made in the percentage of nerve-stretching cures, were the gentle hand of correcting time not inhibited by hasty publication.”—King’s Co. *Proceedings*.

SUDDENLY TURNING GRAY.—Staff-surgeon Parry, while serving in India during the Mutiny, saw a strange sight. Among the prisoners was a sepoy of the Bengal army. He was brought before the authorities, and put to the question. Fully alive to his position, the Bengalee stood almost stupefied with fear, trembling greatly, with horror and despair plainly depicted on his countenance. While the examination was proceeding, the by-standers were startled by the sergeant in charge of the prisoner exclaiming, “He is turning gray!” All eyes were turned on the unfortunate man, watching with wondering interest the change coming upon his splendid, glossy, jet-black locks. In half an hour they were of a uniform grayish hue.

Some years ago a young lady who was anxiously awaiting the coming of her husband-elect, received a letter conveying the sad tidings of his shipwreck and death. She instantly fell to the ground insensible, and so remained for five hours. On the following morning, her sister saw that her hair, which had been previously of a rich brown color, had become as white as a cambric handkerchief, her eyebrows and eyelashes retaining their natural color. After a while the whitened hair fell off and was succeeded by a new growth of gray. This case coming under the observa-

tion of Dr. Erasmus Wilson, shattered his unbelief in the possibility of the sudden conversion of the hair from a dark color to snow-white. No man knows more about the hair than Dr. Wilson; but he is at a loss to explain the phenomenon quite to his own satisfaction. "If," says he "it be established that the hair is susceptible of permeation by fluids derived from the blood—a transmission of fluids from the blood-vessels of the skin into the substance of the hair really occurs, the quantity and nature being modified by the peculiarity of constitution or state of health of the individual—it follows that such fluids, being altered in their chemical qualities, may possess the power of impressing new conditions on the structure into which they enter. Thus, if they contain an excess of salts of lime, they may deposit salts of lime in the tissue of the hair, and so produce a change in its appearance from dark to gray." Then he tells us: "The phenomenon may be the result of electrical action; it may be the consequence of a chemical alteration wrought in the very blood itself, or it may be a conversion for which the tissue of the hair is chiefly responsible." So many "may-bes" from such an authority prove that the mystery of the sudden whitening of the hair is yet unsolved. It is likely to remain unsolved, since the doctor—more modest than many of his brethren—owns that "the mysteries of vital chemistry are unknown to man."—From "*Sudden Whitening of the Hair*," in *Popular Science Monthly*, for August.

A NEW METHOD OF EMBALMING BODIES AND PRESERVING TISSUES.—Dr. Virodteff recommends the following preparation as an efficient agent in the embalming of bodies and the preservation of tissues: Thymol, 5 parts; alcohol, 45 parts, glycerine, 2,160 parts; water, 1,080 parts.

It is cheap, innocuous, free from unpleasant odor, possesses the property of keeping the body soft, elastic, fresh, and life-like, and does not ruin instruments. Thymol is selected as being superior to other antiseptics, and glycerine is added, both on account of its own preservative qualities, and to retard the evaporation of the fluid. For the preparation of tissues, the same solution is used. If the cadaver be quite lean, or the tissues very delicate, equal parts of water and glycerine (1,620 of each) are combined with the above quantities of thymol and alcohol. To inject a body, half its weight of the fluid is necessary. A properly embalmed cadaver may be preserved indefinitely under ordinary circumstances, gradually shrinking and mummifying without putrefaction. Specimens are either to be injected with or macerated in this fluid. Maceration must not be too prolonged—the appearance of the specimen should act as a guide. The part, after having been thoroughly cleansed in water, and prepared, may then be exposed for months to the air without losing its consistence, form, and color. Permanent specimens may be inclosed in a hermetically-sealed glass vessel containing a little of the same solution. The *Medical Record* says that Dr. Peabody has used this preserving fluid with excellent results in the New York Hospital Museum.—*New Remedies*.

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SOME OF THE SOURCES OF DANGER IN, AND THE TREATMENT OF, TYPHOID FEVER.

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Observation can hardly fail to impress upon the mind of the practitioner that all forms of acute disease are of the nature of an accident; that like a broken limb, or gunshot wound, they are characterized by an inherent tendency to recovery, and by processes of repair which are definite in their character and in the periods of time necessary for their completion. Perhaps the entire range of acute diseases will not furnish a better illustration of the truth of this proposition than typhoid fever; because we know more of the method of the agencies that operate in its causation than we do of those that operate in the production of such diseases as measles and scarlet fever, and, while viewed in the light of an accident itself, its course, duration and final termination, depend, largely, upon freedom from accidental complications. The study of typhoid fever involves many points of interest, and a few that are of vital importance. It is the latter that I shall more especially consider in this paper, because they embody the chief sources of danger in the disease.

Typhoid fever has two principal types, which agree at their beginning and end, but not in their middle course. The first lasts only three weeks, and is accompanied by only slight infiltration of the plexus of intestinal glands, the cure coming easily. The second lasts from four to six weeks, sometimes much longer, and presents extensive and successive glandular deposits, with ulceration, and tedious restoration, the cure often being hindered by intercurrent febrile attacks, complications and accidents. In

cases extending beyond three weeks, we then have no means of knowing certainly the length of time that the disease will be prolonged.

Again, the course of typhoid fever is pursued with such unmistakable regularity that it is, next to remittent and relapsing fever, the very best proof we have of the theory of types in disease. Then the methodical nature of the disease is further instanced by its unvarying thermomertic manifestations during the initial stage. When this fever is once fairly developed, the individual attacked is subjected to a great physiological storm, that expends its fury on the nervous, absorbent and nutritive systems, and there is no more use attempting to arrest its progress or cast out the disease, than there would be planning to arrest an eruption of Mt. Vesuvius by casting bucketfuls of water in at its crater. We must wait for the system to deal with the fever and set on foot again the functions that have been prostrated, the practitioner being a watchful spectator, whose chief duty consists in guarding his patient against the special hindrances that may obstruct the normal course of the malady, and in assisting the suffering system in its own efforts at restoration. Just here the value of experience in the management of the disease becomes especially apparent; for in order that the practitioner may assist nature, he must be not only well acquainted with the chief characteristics of these special hindrances, but he must be familiar with their various methods of occurrence. He will then not venture upon a general engagement and fill his patient with drugs in the expectation of removing the danger entirely, nor will he attempt to match his strength against that of the disease, with the view of cutting it short, but will content himself in attempting to guide his patient safely past the threatened danger. Experience begets method, and naturally inclines the observant practitioner to classify the special dangers of typhoid fever somewhat after the following plan, viz: Dangers, first, from hyperpyrexia; second, from starvation; third, from self poisoning; fourth, from other agencies, such as pregnancy, malarial infection, visceral inflammations, etc.; fifth, from accidents, such as intestinal hemorrhage, perforation of the bowels, bedsores, and the like. Recognizing the convenience of the above classification, I will briefly discuss the various physical changes and dangers incident to the different divisions.

Hyperpyrexia has been assigned the first place, because at least two of the above stated sources of danger are so intimately connected with it as to be almost inseparable from it. The physical changes caused by hyperpyrexia consist chiefly in cell destruction in the tissues affected, and especially in an alteration in the blood, which becomes hyper-alkaline, viscid, and abnormally dark in color. This change gives rise to changes in the voluntary muscles which becomes dry, deeper in color, with the fibrils granular, fatty, or waxy, and thus unfitted for the performance of their individual functions. These changes also occur in the tissues of the heart, which are frequently so greatly

damaged that cardiac paralysis is one of the most frequent sources of danger in typhoid fever. Fatty degeneration of the liver, with destruction of the hepatic cells, is another result. In the kidneys, also, the same degenerative changes are met with. The lymphatic and ductless glands become enlarged, softened and frequently the seat of extensive disorganization. Finally, the nerve pulp is affected, and, in case of coma and death induced by hyperpyrexia, we find fatty degeneration of the nerve fibres, softening and pigmentary alterations in the ganglion cells, sometimes great cerebral edema, and, not infrequently, atrophy of the brain itself. The above brief *resume* will be sufficient to direct attention to the gravity of the subject, and challenge the scrutiny of that class of practitioners who do not seem to attach sufficient importance to the subject of temperature in this or any other form of disease.

Starvation.—Its gravity at once becomes apparent when we reflect that considerably more than one-half of the cases of acute disease that die, die from this cause alone. The digestive organs are among the first to give evidence of the presence of the typhoid poison, as is shown by the nausea and vomiting that occur so early, and by the loathing of food and diarrhea that come on a little later. The initial derangement of nutrition is due, probably, to the fact that the function of the glandular apparatus of the digestive tract, is interfered with and crippled, first, by the deposit of the typhoid poison in the glands themselves, and, second, by the paralyzing effects of the high temperature. It is probable that the latter is the chief factor, because it is a physiological law that the living body must maintain a uniform temperature, so as to furnish an unvarying point of distillation from the blood, for its vast glandular apparatus. We can readily understand that nutrition must suffer when the secretions of the glands, which are exceedingly complex organic compounds, accurately adjusted to the mission they discharge, are rendered absolutely unfit for the purposes of life. The evidences of this are the dry skin, thirst, and scanty urine that are invariably present. Another factor in the impairment of nutrition is the weakened condition of the muscular structure of the stomach, which prohibits the reduction of ordinary food to that condition which properly fits it for the solvent action of the digestive juices. This, in connection with the crippled glandular functions, reduces the digestive power to a condition of weakness that has but one parallel—that of infancy. When we couple this condition of weakness with the careless method often pursued in feeding fever patients, it is by no means wonderful that starvation occupies a prominent place among the dangers. The practitioner should prescribe a method of alimentation suited to the capacity and wants of the patient, and he should possess sufficient firmness to restrain friends from administering improper articles of food.

Self-poisoning.—If an excessively high temperature has involved the excreting glands and interfered with that constant depuration of the blood

necessary to its relief from impurities inimical alike to health and to life, self-poisoning, the third source of danger comprised in our classification, claims attention. The inevitable result of a suspension of this function must be to charge the blood with the effete matter of decay, thus furnishing the very best pabulum for the reproduction of the fever virus in the patient, and the consequent prolongation of the disease through several hebdomadal periods. The danger of self-poisoning is especially incident to cases of high morning and evening temperatures, and particularly in persons past middle life, whose glandular structures are undergoing the degenerative changes incident to advancing age. The danger is greatly modified, indeed almost entirely obviated, in those cases where the morning apyrexia is well defined, the functions of the emunctories, in this instance, manifesting great activity, as the congestion induced by the high temperature of the previous evening subsides. This fact is of paramount importance when considered in connection with the therapeutic and dietetic management of the disease.

Other morbid agencies, and conditions modifying the course of the disease, may be disposed of in a few sentences. Pregnancy is an extremely unfortunate complication; miscarriage occurs in about five-sixths of the cases, and death in about one-fifth. Chronic diseases of the respiratory and nervous system do not influence the course of the disease to the extent that we would expect at first glance, although they increase the gravity of the situation in an appreciable manner. Chronic disease of the heart exercises an extremely unfavorable influence, and adds much to the danger by augmenting the risk of cardiac paralysis. Malaria, as a rule, neither increases the aggregate severity nor effects the ultimate result. It does, however, often change the time of the pyrexia, so that the greatest elevation of temperature will be noted early in the morning. At other times the disease, when complicated, winds up with an intermitting form of fever, which is often extremely rebellious to treatment with quinine, but yields quite readily to the effects of arsenic.

The accidents will be discussed in connection with the review of the therapeutical measures indicated for their relief.

-TREATMENT.—When the practitioner takes charge of a case of typhoid, he is just as fully bound to protect the healthy members of the family and all persons who may come within the radius of infection, as he is to put forth his best effort for the cure of the sick. Prophylaxis will accomplish much in this connection, if we recognize typhoid fever as a miasmatic contagious disease; one in which the special poison cannot be transmitted directly from one person to another, but must pass through a stage of development outside of the body before it can produce the disease in another individual. Such quiescence becomes fatal if it be at this time acted upon by agents capable of destroying it. Assuming

that the above is correct, something like the following system of prophylaxis should be instituted whenever the disease makes its appearance. The privy vault should be disinfected by the use of a sufficient quantity of a mixture of equal parts of manganate of soda and sulphate of magnesia; the moisture present forms a permanganate of soda which is decomposed by the impurities present, producing ozone, which is a powerful disinfectant and deodorizer. Afterwards the vault may be preserved in a healthy condition by the process already described, or by covering the contents every few days with a mixture of two parts of chlorinated lime and one of charcoal reduced to a coarse powder. All other accumulations of filth should be treated in a like manner. The well should be cleansed and disinfected by covering the bottom with the soda and magnesia mixture and by burning sulphur in some kind of vessel that will permit its being carried upwards and downwards in the well throughout the entire length of its shaft. The filth removed should be disinfected so that it may not prove a source of infection. If the well should be a source of apprehension it should be closed up entirely. In this way the two probable sources of infection are purified and preserved in a healthy condition.

For the purpose of securing the greatest perfection possible in prophylaxis, the patient should be placed in an isolated spare room, with bare walls and floor, containing, aside from two beds, a table and a few chairs. Thorough ventilation *must be provided for*. The patient should be thoroughly cleaned each day, and placed in the spare bed, the one in use the previous day being taken out of doors and, with such articles of bed-clothing as cannot be conveniently washed, exposed for some hours. All sheets, pillow-cases, napkins, handkerchiefs, rags and the cast off linen of the patient, should be thoroughly boiled daily. The excretions of the patient should be submitted to a rigid system of disinfection, and previous to using the bed-pan its bottom should be covered with the soda and magnesia mixture or with a mixture consisting of one pound sulphate of iron, and one ounce of creosote, or crude carbolic acid, in one gallon of water. The excretions should be deposited in a sink or trench provided for the purpose, in such a situation that it cannot affect the well by drainage: this sink should be constantly disinfected. The patient's room should also be disinfected by a well regulated elimination of ozone by means of phosphorus. For this purpose half a stick of phosphorus should be placed on a plate with a sufficient quantity of water to immerse two thirds of it; the plate, placed out of reach of accident, should be under constant observation, and the liberation of ozone permitted until sufficient has been liberated to meet present indications. When the disinfection of the room is complete, the process can be suspended by covering the phosphorus with water.

If the above measures of prophylaxis are faithfully carried out, I am

convinced that typhoid fever will, in but very few instances, extend beyond the first individual attacked.

The practitioner, having thus far divided his attention between the patient and his friends, should now devote it, exclusively, to the patient himself. No careful practitioner would think of risking further damage to the already crippled nervous system, or would court the danger of rendering the stomach still more intolerant, by the administration of 40, 60, or 80 grains of quinine for the purpose of reducing the temperature, that reaches at most 103° in the afternoon, and then drops down to 101° or 100° by the following morning; just because Juergensen, Liebermeister, or some other noted authority had said that large doses of quinia were efficient in high temperature; or what physician of experience would think of permitting his patient to remain in an ice-water bath after his temperature had descended rapidly from 105° or 106° to 100° or below, and thus subject him to the danger of sudden and perhaps fatal collapse, simply because some noted clinician had said the bath was a powerful agent in saving the heart and nervous system in cases of typhoid fever. Yet an ordinary routine method of practice is pregnant with such dangers. Cold and quinia judiciously applied, are all-powerful to do good; they are also, when indiscriminately used, capable of doing great and even fatal mischief. I wish to be understood as authorizing the full effects of cold only in those cases where there is a persistently high temperature, mounting from 102 to 103° in the morning, to 104 and 105° and even higher in the evening. Such cases call imperatively for relief, and in case it should be impossible to meet the indication with cold, the practitioner should resort to antipyretic doses of quinia, and persist in their exhibition until success crowns his efforts. A separate indication for the use of quinia is the elimination of the malarial complication so frequently present in the first week of the disease, but full antipyretic doses are not required for this purpose.

With reference to the application of cold two methods recommend themselves; the bath, and the pack, as administered on Kibbe's fever cot. This cot may be extemporized by fastening a strong open-work cotton blanket to the side rails of an ordinary single bedstead, while a rubber cloth is attached in such a manner that it slopes towards the foot, so as to carry off the water into a suitable receptacle. The patient is placed upon the cot under a folded sheet, upon which cold or iced water is poured until the desired reduction in temperature is secured. Afterwards he may be removed to his bed, and covered with a light blanket. If the temperature speedily overcomes the effect of the cooling, the patient, with a folded woollen blanket under him, may be made comfortable and so remain upon the cot, and have the application of the cold renewed as needed. The application of cold should always be made under the guidance of the thermometer, and must be

continued until the temperature has been reduced to the desired point. When the temperature commences to fall, thermometric observations should be made every three minutes. If the mercury sink rapidly, say two degrees in five minutes, or three degrees in ten, the patient should be removed from the bath, no matter what degree of temperature is indicated, because it will continue to run down for an hour, and frequently for a still greater length of time, and there is danger, if the bath be prolonged, that the patient may be precipitated from the dangers of a torrid temperature to others of equal gravity, incident to the frigidity of collapse. If the temperature be 104-5 degrees, the application should be suspended when the thermometer indicates 101 or 100 degrees; for a further declension to 99 or 98 degrees will occur; or if the patient should remain in an iced bath or pack for twenty minutes, and his temperature only fall to 102 degrees, it would be safer to remove him than to permit him to remain longer. If a bath be administered to a patient during the first week of a fever, who has a temperature of 105 degrees or above, and it should sink to 99 degrees or thereabouts in a period of ten minutes, it is almost conclusive evidence that it is not typhoid fever, but some other complaint. If a patient is unable at first to bear a bath sufficiently cold, Ziemssen's plan of placing him in a bath more nearly the temperature of the body, and then gradually reducing it by the addition of ice, may be resorted to. The number of applications in twenty-four hours will be regulated by the rapidity with which the temperature rises; and may in some instances reach as many as twelve, while in others two or three will be sufficient. The good effects of the application of cold are made apparent in the generally bettered condition of the patient. The disease will not be cut short by its employment, but the patient's chances for recovery will be greatly increased.

Notwithstanding the acknowledged efficacy of cold in subduing hyperpyrexia, there are, unfortunately, a great many instances in which we are deprived of its benefits. It is not often that the practitioner can spare the time to superintend a bath, and it would not be safe to delegate it to any but trained nurses, and these, unfortunately, are not often found. Or the fears of the patient may preclude its use, or the friends will become alarmed and enter protest the moment it is suggested. Hence it is fortunate, indeed, that we are in possession of medicinal agents having antipyretic properties. Quinia possesses this power in a degree but little, if at all, inferior to cold, and when given in sufficient quantities, and at the proper time, will seldom fail. If a bath be given in from eight to twelve hours after the administration of an antipyretic dose of quinia, the effects of the cold will be greatly prolonged. Quinine is best given at bedtime, so that its effects will be in full operation with the occurrence of the morning apyrexia. If the patient's stomach be retentive, 30 or 40 grains may be given at once without prepara-

tion; but should vomiting be apprehended, give $\frac{1}{8}$ or $\frac{1}{4}$ of a grain of morphia, and after the lapse of $\frac{3}{4}$ of an hour apply a sinapism to the epigastrium, and with the occurrence of the cutaneous redness incident to the application, the quinia should be administered. If at the expiration of 24 hours no change in the temperature is observed, 50 or 60 grains should be given. Such or even larger doses of the drug should be given whenever there is a continuously high temperature, with but little difference in the morning and evening indications, until it is brought into subjection. Quinia does not arrest the course of typhoid fever, nor cut it short, but its intelligent employment will most assuredly do much toward tiding the patient safely over the dangers of long continued high temperature.

Other agents, such as digitalis, veratrum viride, aconite, and gelsemium, seem to possess antipyretic properties, but they are all inferior to cold and quinia; still, if the latter agents are contraindicated, or should fail in reducing the temperature, a combination of veratrum, aconite, and gelsemium may be used, such as has been recommended by Dr. Wm. H. Thompson, for the reduction of temperature in phthisis. The following is his formula: *R* Tr. virat. vir.; ext. gelsemini, fl., aa 3j; tr. aconiti rad., ʒvj. *M.* *Sig.* Five drops every two hours. Watch the pulse, and upon the first sign of intermission in its beat, or real slackening of its rate, the dose should be either greatly reduced, or withheld entirely.

The typhoid fever patient, if severely attacked, should be fed like an infant. He should have fluid food, so that no demand will be made on the weakened muscular coats of the stomach. It should embrace everything necessary for complete physical repair. Milk, pure sweet milk, has been aptly termed, "fluid flesh, bones, and nervous matter," and this is the food, par excellence, for the typhoid fever patient, and will meet in the most efficient manner all the wants of his weakened organism. It may occur that some solvent will be required for the casein; if so, lime water, in the proportion of $\frac{1}{3}$ to $\frac{1}{2}$, will meet the indication in a way that will leave nothing to be desired. There is scarcely any limit to be placed upon the quantity; it should be as much as the patient can take and dispose of with comfort, and may amount to several quarts daily. The weakened digestive powers may be aided by the exhibition of ten grain doses of Scheffer's or Jensen's pepsin, in solution with 15 or 20 drops of dilute hydrochloric acid, given an hour after taking milk. The pepsin will aid digestion, while the acid discharges the several functions of tonic, antiseptic, and restorative. Just here I may remark that no other agent can be found so eminently fitted for restoring and preserving the epithelial covering of the mucous membrane of the alimentary canal, as hydrochloric acid. Its beneficent action is manifested at both ends of the tube, as will be observed in the cleaner and moister condition of the tongue, and the better looking and less frequent

alvine discharges. The monotony of the milk diet may be broken by the exhibition of meat juice, combined with some farinaceous article in a state of fine division. The meat juice should be prepared by placing a piece of lean beefsteak in a hot skillet, under a hot lid, until it is heated sufficiently to start the flow of juice from the fibre. The juice should then be expressed from the meat with a lemon squeezer, and well salted to prevent fermentation. This answers well for purpose of stimulation in greatly weakened heart, but good pure milk should be the dietetic sheet anchor in this fever. Solid food is not admissible; first, the unbearable loathing it usually excites would quite probably induce vomiting; second, on account of the weakened condition of the stomach, it would not be brought into a condition compatible with complete digestion; third, in the absence of the normal digestive juices, it would, if not vomited, lie for some time as mere foreign matter in the stomach, undergoing fermentation and decomposition, and then, passing away by diarrhea, accompanied with the evolution of enormous quantities of gas, would intensify the already existing tympanites; finally, the passage of indigested food over the points of ulceration might cause perforation, with resulting peritonitis and death. The giving of nourishment is usually distributed equally over the 24 hours, but I am satisfied that by far the greater amount should be given during the usual daily defervescence, because the functions of the digestive tract are much more active when it is relieved of the congestion and dryness which accompanies the hyperpyrexia. The celebrated Dr. Graves was fond of exhibiting food during the day, and nothing but fluids at night; arguing that it was not best, even in sickness, to interfere with the diurnal revolutions of the economy; but I am satisfied that the greatest amount of food should be given at such times as the digestive organs can best dispose of it, be it day or night.

Self-Poisoning.—If the temperature be controlled to a maximum of 103° with a minimum of 100° or 101° , if the amount of aliment be sufficient, if the functions of the skin and kidneys maintain a moderate degree of activity, and the bowels are opened once or twice daily, we need have but little apprehension of the third source of danger in this fever, viz.: self-poisoning. If, however, it should occur with more than ordinary severity, I do not believe there is any treatment which promises more than the line already described, with the addition of stimulation. I do not believe it possible to eliminate or neutralize the poison, although much may be done to support the powers of life during the period of its activity. A great deal has been said in regard to calomel, iodine, and iodide of potassium, in "unlocking the secretions" and promoting the elimination of the poison; but it has already been shown that it is a high temperature that causes arrest of function in the glandular apparatus, and that these functions are resumed again with an apparently increased activity upon removal of the fiery incubus. The first clause of the

above proposition argues the importance of calomel and the preparations of iodine as eliminators, while the second clause proclaims emphatically the value of cold externally, with quinia and an abundance of cold water internally, because these agents reduce fever heat. The water used to quench the thirst acts in the capacity severally of antipyretic, diuretic, and diluent for the poison.

Complications and Accidents.—About five out of ten of pregnant women attacked miscarry. Previous to the adoption of the antipyretic treatment, about three-fifths of those attacked succumbed: since that time, as nearly as I can learn, about one in five dies. Obviously then we expect better results in cases thus complicated if the temperature is closely watched, and its too great elevation energetically combatted. Owing to the unsettled condition of the professional mind as to the oxytocic properties of quinia, it would be the better plan perhaps to rely entirely upon the application of cold in these cases, for the purpose of reducing temperature.

Chronic disease of the heart adds much to the gravity of the affection, on account of the increased danger of cardiac paralysis, and calls loudly for antipyretic treatment in order to prevent the mischief that will otherwise most surely occur. In these cases one-eighth of a drachm of tincture of nux vomica should be given thrice daily, with the pepsin and acid mixture. If paralysis is seriously threatened, as shown by the quickened pulse and weakened or muffled first sound, free doses should be added of good brandy or whiskey, with from one-half to a drachm of spirit of chloroform, or a drachm of Hoffman's anodyne, with every second dose of the alcoholic stimulant. If the paralysis should actually occur, heat should be applied to the epigastrium, by means of heavy porcelain sauce dishes dipped in hot water, brandy should be used hypodermically, water as hot as the rectum will bear should be thrown into the bowel, and, should reaction still fail to occur, the patient should be wrapped in a blanket wrung out of strong hot capsicum or mustard tea; and finally, if all other means fail, he should be placed in a bath with a temperature of about 103°.

Chronic diseases of the respiratory organs do not call for any special modification of treatment, further than a more persevering effort to protect the powers of life. Pneumonia is liable to be accompanied with more or less pulmonary edema, and should be combatted by the exhibition, every third hour, of ten grains of carbonate of ammonia in combination with small doses of camphor.

Diarrhea, if it cause more than one or two alvine discharges daily, should be controlled, preferably by enemata of five or six ounces of starch, which may or may not contain opium. If there should be much pain preceding or accompanying the stools, laudanum may be added. This method of controlling diarrhea appears the more rational when we reflect that it will

not be likely to occur unless the colon is involved in the ulceration; in which case the starch will protect the rectum and sigmoid flexure from the acrid secretions of the bowels, and thus restrain the frequent motions. Again, drugs administered by the mouth for the purpose of checking diarrhea have to pass through twenty-five feet of intestine, and disappoint us more frequently than otherwise. If drugs become necessary, I am partial to a combination of $\frac{1}{2}$ or 1 grain of opium to 25 or 30 grains of bismuth, given every three or four hours until the diarrhea is controlled.

If *hemorrhage* from the bowels occur, the practitioner in his anxiety to do something will most likely resort to astringents, such as lead, tannin, gallic acid and the like; but a more moderate course should be pursued, since more than likely the hemorrhage has cured itself, before a single particle of blood has made its escape from the rectum, and it only remains for the practitioner to give a few small doses of opium to control peristalsis, and apply ice to the abdomen, more for the purpose of quieting the fears of the friends than arresting the hemorrhage. If, however, the patient become suddenly much weaker, with the skin cold and pale, the heart acting feebly, and the pulse frequent and weak, with dullness upon percussion over the abdomen where tympanitic resonance had been recognized but a short time previously, the practitioner would be justified in concluding that a sudden and extensive hemorrhage was occurring, and he should proceed promptly with the application of ice to the abdomen, and the administration hypodermically of one-eighth of a grain of morphia and three to five grains of Squibb's ergotine.

Perforation.—There is but one method of treatment for perforation of the bowels, and that is opium in any quantity that will produce semi-narcosis.

Delirium requires careful watching. The patient should never be left alone after he once begins to descend the curve, because delirium is liable to occur at any moment, and he might do something that would result disastrously. The milder forms of delirium usually give way to the antipyretic treatment, but if it should be an urgent and persistent symptom in the earlier stages of the disease, and other means fail to arrest it, we may resort to the use of Grave's mixture: R Ant. et potas. tart., gr. iv.; tinct. opii, ʒj; aq. camphoræ, ʒviij. M. Sig. Tablespoonful every second hour, until the desired effect is obtained. When delirium occurs late in the disease, it is a symptom of cerebral exhaustion, and is best treated with alcoholic stimulants. I have many times witnessed a patient who in his incoherency seemed determined to leave the bed and "go home," quiet down nicely and fall into a gentle slumber through the instrumentality of two or three full doses of egg-nog.

Bed sores add much to the gravity of the situation, and their occurrence

should be anticipated by thoroughly bathing each point on which pressure is expected, several times daily with a mixture of one part of nitric ether to three of water. If a slight abrasion of the skin occur, it should at once be covered with a solution of one part iodoform to fifteen of collodion, and pressure removed from the injured point. If the broken skin be much inflamed and accompanied with a hardened base, the covering of collodion and iodoform should be fortified by the addition of numerous layers of absorbent cotton, each layer of cotton being saturated and fastened with collodion applied with a large, broad camel's hair brush, and a rubber cushion filled with air or iced water, placed under the damaged part. It is an admirable plan to have two rubber cushions, one filled with air and the other with iced water, and use them alternately, removing the one filled with iced water whenever the water becomes heated, and replacing it with the one filled with air, resorting to the first one again whenever the part has recovered from the effects of the previous cooling. If necrosis occur, the dead tissue must be gotten rid of as speedily as possible by means of poultices and excision; after which the sore should be dressed with a mixture of creasote two parts and vaseline five parts, until granulations make their appearance, when the cavity should be made to fill as rapidly as possible by being drawn together with adhesive straps. The foregoing plan of managing bed sores I can heartily commend, after testing its efficacy in quite a number of cases. I have had no experience in the use of the bath for the treatment of bed sores as recommended by Liebermeister, but think favorably of it in case it can be conveniently reduced to practice.

A resume of this paper involves three or four points that should always be borne in mind. 1st. We cannot cure this fever. 2d. We cannot cut it short. 3d. We can increase the patient's chances for getting well. 4th. The third proposition is compassed by combatting long continued high temperature, and by physiological feeding and proper treatment of complications and accidents.

A CASE OF PERIMETRIC HEMATOCELE.

BY W. B. MARPLE, M. D., WASHINGTON C. H., OHIO.

Mrs. S——, aged 19, married about eight months, well nourished; previous health has been tolerably good, though some years ago she was a sufferer from acute rheumatism and anemia. She began menstruating when twelve years of age, and has always menstruated pretty freely. There has been no menstrual irregularity since her marriage. She ceased menstruating on September 18th. Two weeks subsequent to this, on Sunday, October 1st, 1881, she began to "waste," to use her expression for metrorrhagia.

The flow continued to increase until Thursday, October 13th. About five o'clock that morning she experienced severe pains in the hypogastric region, in the vicinity of the uterus. Later she perspired profusely, and vomited. The pain continuing she rode into town to see Doctor X——. She was then bleeding, or wasting, considerably, and he inserted a plug of cotton into the vagina, back of the cervix, with directions to remove and renew in twenty-four hours. Friday she removed the tampon and inserted another, but soon had to remove it on account of the pain it occasioned. The pain and hemorrhage continued, the former especially being exceedingly severe. The following Monday night, about eleven o'clock, Dr. Foster was called to the case, and it was through his kindness I was enabled to see it. The sufferings of the patient were then intense, and had been so for twenty-four hours or more, compelling her to writhe, and cry out in agony. She would clutch the bed-post, or would ask to hold the arm of the nurse, in order to "help her bear the pain." This pain was paroxysmal in character, although there was more or less of dull pain constantly present. There was great difficulty in making water, and constant illusory desire to defecate.

Examination per vaginam revealed the following: It was well nigh impossible to reach the os uteri, as it was pushed up out of reach. Encroaching on the posterior wall of the vagina was a tumor, which was nearly the size of a goose-egg. The tumor was somewhat elastic, and appeared to occupy Douglass' cul-de-sac. There was at that time only slight discharge from the vagina. Examination per rectum revealed the tumor, and also the fact that the rectum was entirely empty, although there was a catarrhal secretion from the rectal walls. There was only slight tenderness over the abdomen, especially marked in the hypogastric region, and slight tympanites. The pulse was 115 and weak; temperature ranged from 100° to 102° F. Although for scientific reasons it would have been interesting to have passed the sound, yet it was thought best for the patient to omit this.

The diagnosis was retro-uterine hematocele. The patient was given a quarter of a grain of morphia per os immediately, to be repeated in an hour and a half, and after that often enough to relieve the pain. On visiting her the following morning, it was found that the severity of the pain had been much diminished after the second dose of morphia, although the paroxysms of pain, though much diminished in severity, continued for some time.

There was nothing of particular interest in the case for four days, during which the treatment consisted of morphia, to relieve pain; stimulants occasionally; perfect quiet in bed on the back (during which time a request for a "physic" was refused); and, finally, care was taken that she have good nourishment at regular intervals. Saturday there was a circumscribed soft spot on the right side of the tumor (where it encroached on the vagina) at its lower part. She was directed to have warm water injections into the vagina

occasionally during the day, but their use was suspended soon, as the patient complained that they pained and nauseated her. Sunday morning, October 23d, ten days after the appearance of the tumor, about one o'clock, the patient commenced to have a bloody flow from the vagina. This continued and was rather free for about six hours, till seven o'clock Sunday morning. Then the character of the discharge appeared to change, becoming now serous, or like bloody water, as the attendants called it. It gradually diminished in quantity till Sunday evening, when I saw her. Then the discharge was hardly perceptible. Examination per vaginam now revealed the fact that the os had perceptibly descended, and was reached with comparative ease. The tumor had disappeared, and at the spot which was soft at previous examination, could now be felt plainly a little rent or opening in vaginal wall. Pain during Sunday and ever since October 23d, has been slight and easily relieved; the appetite and strength are returning. The patient, notwithstanding repeated admonitions to keep quiet in bed for a few days, was soon on her feet at her household duties. I have expected since to hear that she had another attack, but as yet (November 18) it has not come.

In regard to the cause, it is safe in this case to exclude pregnancy, normal or extrauterine, abortion, injury to abdomen, etc. The most probable cause is to be found in the menstrual disturbance.

Here the menstrual molimen began two weeks ahead of time, and was attended with metrorrhagia from which she suffered for ten days before she had any symptoms of hematocele; so that the general pelvic congestion incident to the abnormal menstruation may be set down as the principal cause of the hemorrhage, as it was in several of Barnes' cases. As to the exact location of the hemorrhage, there are one or two features about the case which incline me to the opinion that the effusion was into the right broad ligament. If we have the hemorrhage into the peritoneum, marked symptoms of acute peritonitis will *probably* ensue. But in this case many of these symptoms, such as tympanites, tenderness over the abdomen, etc., were absent, making it probable that peritonitis, if present, was very slight and circumscribed, and consequently that the hemorrhage was extra-peritoneal. Again, Barnes says that Douglass' cul-de-sac is not symmetrical, but that it extends one or two inches lower down on the left side than on the right. If this be so, and Barnes is quite positive in regard to the matter, we should expect to find on vaginal examination, the bulk or greater part of the tumor on the left side, provided the hemorrhage was intra-peritoneal and into Douglass' cul-de-sac. This, however, was not the case. The tumor was lowest and largest to the right, and its contents escaped by an opening distinctly to the right of the median line. Hence it is probable that in this case the effusion was extra-peritoneal, and in the layers of the right broad ligament.

MALARIAL HEMIPLEGIA.

BY GEO. A. COLLAMORE, M. D., TOLEDO, OHIO.

The occurrence of cases of paralysis, evidently due to malaria, is so rare that I will put on record the following, the only case which has occurred to me in a practice of over twenty years, mostly in a malarial region :

John W., of German parentage, aged eight, was on his way to school, Dec. 9, 1880, in apparently good health, when, without warning, he fell and had a fit. This is the testimony of the children who were with him. That is, he "worked" his arms and legs. He was taken home and I was sent for, but did not see him that day. Dr. Kirkley, who saw him, said the boy was paralyzed and presented about the same appearance as on the next day.

I saw him on Dec. 10. He then had high fever. There was total paralysis of the left side, the muscles of the face, arm, and leg being involved, sensation also destroyed. The eyes were especially affected, being strongly turned to the left, totally blind, and immovable. Speech not affected. Combined with the paralysis was a shaking of the head from side to side, involuntary, and lasting for hours at a time.

On Dec. 11 the paralysis continued. There had been the choreic movements of the head for an hour and a half. He had also a feeling of suffocation and palpitation of the heart. About 4 A. M., Dec. 12, the paralysis had all disappeared and the boy was comparatively well. At the same hour on the following morning he had a chill, followed by fever, shaking of head, also nutation or nodding of head, sense of suffocation, shaking of left arm by spells all night, and stiffness of the muscles of the neck. Temp., 99.6°; pulse, 100.

Dec. 14. Shaking has disappeared, fever slight. Temp., 99.4°. After this the fever entirely subsided and the patient recovered in a few days, and has remained in good health ever since.

The treatment was that appropriate to intermittent fever, mainly quinia in large doses. A few doses of calomel were also given.

It must be acknowledged that the complete paralysis of both motion and sensation of one-half the body, together with the paralysis of the optic nerves, succeeding a convulsion, presented an array of symptoms sufficiently formidable, and one which might fairly lead one to suppose that some actual, grave physical lesion had been produced in the brain substance, which would render the prognosis very doubtful. For three days, while the paralysis continued, the conclusion could hardly be avoided that the brain had suffered an injury, which would probably result in permanent disability. The occurrence of a chill succeeded by fever on the fourth day, cleared up the diagnosis, and in view of the fact that it did not recur after full doses of

antiperiodics, it was concluded that the case was one of intermittent fever with unusual concomitants.

The appearance of convulsions in children during the existence of a chill or fever of malarial disorders, is sufficiently familiar. They are epileptiform in nature, and are seldom followed by serious results. Authorities tell us, however, that epileptic paroxysms may be followed by hemiplegia with unknown brain lesion, which paralysis is apt to be permanent. West, in his work on diseases of children, reports two cases of hemiplegia attributed to malarial poisoning, both of which persisted for years. In these cases it is probable that some injury was inflicted on the brain substance, which disabled it permanently. At a meeting of the Neurological Society of New York, reported in the *Medical Record* of Dec. 17, 1881, Dr. Gibney read a paper on "Intermittent Spinal Paralysis of Malarial Origin." Two cases were reported, one in a boy of seven, who had five attacks of paralysis of the four extremities, from the first four of which he recovered, but was still uncured of the last after four months of treatment. The second case was that of a boy of six, with paralysis of the legs. From two attacks he recovered, but in the third he had paralysis of all the extremities and died. These cases seem to have been of a different character from the one here reported. Dr. Gibney referred to the fact that intermittent spinal paralysis was very rare indeed, only a few cases having been recorded. He stated that the literature of malarial poisoning is full of neuroses, and that Trousseau thought that very nearly all the symptoms in masked malaria could be explained by referring them to the effect of the poison on the nervous system. Dr. Gibney thought it not difficult to suppose that malarial poison might cause an anterior poliomyelitis, which was the lesion he considered to exist in his first case. He thought his cases were malarial from the fact that they had lived in a malarial country and had had chills.

In the discussion of the paper, Dr. Mary Putnam Jacobi rather dissented from the idea that the cases were of malarial origin, as also did Dr. Seguin. The latter enlarged upon the extreme rarity of paralysis from malarial causes. In many extensive treatises the disease is not mentioned or barely referred to. Dr. Seguin then reported a case of what he termed intermittent post-malarial hemi-numbness.

Dr. Rockwell related a case of intermittent hemiplegia in a man of middle age, which did not prove to be malarial, as after death actual lesions were discovered in the brain. He had seen two unmistakable cases of malarial paraplegia.

Dr. Gray had never seen a paralysis due to malaria. He thought that in the next ten years the attempt would be made to show that malaria is a neurosis, and that now some authors were leaning in that direction.

In the case here reported the pathology is not clear. That there could

have been any actual lesion of the brain is negated by the disappearance of the paralysis and its non-occurrence from the second chill; for I have no doubt that the primary convulsion was in consequence of a chill. The second chill was followed by somewhat different phenomena from the first. The head was nodded as well as shaken from side to side, and the left arm was also in constant agitation, and there was no paralysis.

In regard to the etiology of the paralytic phenomena, the natural suggestion is occlusion of some cerebral artery by an embolus. In consulting Nothnagel's article on that subject in Ziemssen, Vol. XII, I find many confirmatory ideas. I will quote such as are the most appropriate:

"The symptoms which attend the occlusion of a cerebral vessel by an embolus always make their appearance suddenly." * * "It is not uncommon for embolism of the cerebral arteries to give rise to convulsions." * * "In the majority of cases these bear the form of typical epileptic attacks, which invariably come on synchronously with the loss of consciousness." * * "The further history of these cases of occlusion from * * embolism, * * may vary greatly in character: the symptoms may terminate either in death or in complete and permanent recovery; or, after more or less improvement, the attack may recur; or, finally, the district supplied by the occluded vessel may undergo softening, attended with loss of its physiological functions, and the production of permanent morbid symptoms." * * "The motor-paralysis from * * embolism is on the side opposite to the portion of the brain involved. If other vessels are occluded, the paralysis will involve other nerves." "All the different cranial nerves have, at one time or another, been found involved." "The stationary embolic paralyses are precisely like those due to hemorrhage, one point of difference alone calling for notice, which is, that a few cases have been recorded in which, for a long time after the occurrence of the paralysis, convulsive movements were observed to take place in the paralyzed muscles." * * "In a very few cases of embolism, in connection with the other symptoms, amaurosis, from blocking up of the ophthalmic artery, has been observed to occur with great suddenness." * * "In some instances an improvement takes place in the paralytic symptoms." * * "The possibility of the occurrence of this result plainly turns upon whether the cerebral tissues, robbed of their nutriment, can be sufficiently rapidly supplied with the needful amount of arterial blood by way of the collateral circulation. If this is the case, a rapid improvement may occur, noticeable after the lapse of even a few days. Where this improvement concerns the paralysis not only of single nerves, but of all the affected parts, its occurrence may help us to distinguish the disorder from hemorrhage." "After once recovering, the patients may remain permanently in good health." In the diagnosis between embolism and hemorrhage, he says: "One circum-

stance alone seems to be of almost, though not absolutely decisive importance: when, namely, a condition of well-marked hemiplegia, occurring coincidently with the attack, almost or quite disappears within a few days after it, the existence of hemorrhage as a cause would be very improbable."

CASE OF URETHRO-VESICAL DISEASE.

BY S. W. SKINNER, M. D., TOLEDO, OHIO.

Mrs. L., aged 25, mother of two children, had been troubled with an irritability of the bladder for about ten years. At the time of puberty she began to be unable to hold her water on account of the pain and distress it occasioned. This condition had continued, gradually increasing, notwithstanding a great variety of treatment to which she had been subjected by several physicians, until at the time I first saw her in consultation she was obliged to evacuate her bladder every half hour, day and night, passing about a tablespoonful at a time. The urine appeared to be healthy, but she said that it sometimes contained mucus, and occasionally blood. In consequence of the loss of sleep, and the pain and anxiety she suffered, her general health was much impaired.

I advised the use of iodoform ointment, to be applied to the neck of the bladder by means of a catheter. It was, however, found to be impossible to introduce the catheter any farther than the neck, not through it, and the treatment proved only partially successful. A slight violence in the use of the instrument caused quite a flow of blood and great pain. An examination made while she was under the influence of chloroform, showed that the catheter could be passed without difficulty, but the operation was attended by a flow of blood.

It was now surmised that there was a vascular growth near the neck of the bladder, and, learning that she had been subjected to a treatment by nitrate of silver and perhaps other escharotics, we determined to try the effect of acetic acid applied locally. A suitable syringe was therefore provided, and when she was under the full influence of chloroform, about an ounce and a half of common acetic acid was injected through the urethra. Our patient was aroused at once, and rolling from the bed, commenced a series of convulsions which astonished us not a little. The flow of blood was quite profuse, and her distress excessive.

Believing that it would soon pass off, we gave her an opiate and consoled her with the hope of a possible permanent good to be derived from the rough treatment she was suffering from. The next day I found her suffering much pain, not having slept at all during the night. She had passed a little water

with difficulty, and was in a high irritative fever. This condition continued about a week, when her pain and fever very gradually subsided. Her urethra was often obstructed by the passage of plugs of quite firm consistency, having the appearance of being organized matter, and on their evacuation, healthy looking urine followed, and at about the end of a week she was able to retain her urine longer than before the operation, and pleasantly remarked to me that I had nearly killed her, but she guessed I had cured her, for she had slept six hours on the previous night without the passage of urine, and she might have slept longer if she had not been awakened by her baby. The use of the iodoform ointment was now resumed, and she found that she herself could easily pass the catheter into the bladder with little pain and no flow of blood. Steady improvement in her general health and condition has since followed, and our patient is almost as happy as the doctor is to have escaped an unfortunate result.

The lesson to be learned from this case is that the bladder does not tolerate the introduction of substances which are too irritating. That applications which can be made to other mucous surfaces with perfect impunity, are not always borne well by the bladder. Though the results of this case are highly satisfactory, I never expect to pump an ounce and a half of acetic acid into another bladder until every modification of this treatment has failed.

FEIGNED INSANITY.

From the *Etude Medico-Legale sur la Folie*, by Ambroise Tardieu. Translated by Thomas C. Minor, M. D., Cincinnati, Ohio.

If a doubt exists in intelligent minds regarding the exclusive competency of physicians on questions of insanity, that doubt can certainly be dispelled in cases where careful studies of feigned lunacy have been made. It is only by profound knowledge of the real that it is possible to recognize the feigned, and simulation holds a considerable place in the medico-legal history of madness; not that examples of this kind are frequent, but because the expert placed face to face with a person whom justice has commissioned him to examine as to mental responsibility, must, under all circumstances, investigate the possibility of simulation and form a positive conclusion as to whether the insanity to be verified is real. There is, moreover, regarding this subject, an important distinction to be made between the supposition of insanity, or pretended insanity, and the intentional feigning of insanity.

Pretended Insanity.—In the first case, this is only an excuse invoked by the attorney for the defense of his criminal client, instead of a resort to that legal eloquence which, to-day out of fashion, was for a long time the means

used to secure acquittal by a court of justice. As nonsensical and indefensible as such a plea may seem, it is necessary to recognize that it is often employed with success. In such instances the perpetrator of the crime is considered in relation to his pretended insanity, and allows his attorneys to debate the question of his mental condition without aiding them save by a kind of tacit consent, assuming, generally, in the meantime, a passive attitude. But the argument advanced by the defense, has for its support, we might say for its accomplices, on the one hand, the honor of a family seeking to cover up crime by the excuse of insanity and to pass as a lunatic a villain whose disgrace would reflect on themselves, and, on the other hand, a sort of natural tendency, on the part of mankind, to attribute to aberration of reason those offenses which by their grandeur and atrocity, or the apparent strangeness of circumstances under which they were committed, excite popular indignation and harrow the human soul. In a neighboring country the *regicide* is screened by the penal law and treated as insane. I can cite a case in which insanity appeared to offer the only explanation for five murders committed by a nobleman, four of the murdered parties being closely related to the criminal. In another case, a man having killed his wife kept the corpse in the mattress of his bed until it was mummified, and this strange procedure alone seemed enough to authorize the plea of lunacy.

In cases of this kind, justice claims the advice of a medical expert in order to be enlightened as to the value of the pretext. I have often been called in such cases, which are far more frequent than cases of true simulation. Here, the most simple examination is sufficient to determine the truth, for the accused does not take the least pains to imitate insanity or to play the *role* of the lunatic.

The theory of insanity is sometimes advanced by a pandering witness or by an interested relative; sometimes, by a vague notoriety which is established regarding the character and habits of him for whom it is necessary to obtain the legal excuse of lunacy; sometimes the history of an old time disease, or previous attack of more or less pronounced mental aberration, causing, at an anterior period, the confinement of the accused to an asylum. This last circumstance calls for an altogether particular attention on the part of a medical expert. In fact, it is only natural to establish a presumption as to the predisposition of such a person to new relapses; this, however, by itself is no actual and decisive proof of lunacy. It is necessary, under such circumstances, to be very careful in making retrospective inquiries as to former attacks, in order to appreciate exactly their character and signification, and to guard against all causes of error or fraud: also to carefully examine the prisoner as to the crime of which he is most lately accused, exclusive of antecedents. The fact that a man has once been confined in an insane asylum for a transitory mental attack, cannot be deemed a sufficient reason

to account for all the acts he may thereafter commit, even although after a long period of time he might have been suspected of having mental disorder. I have seen numerous cases of this kind and need cite but a few.

A girl detected in petty thefts had, under the garb of religion, an inveterate habit of lying. She was said to be subject to fits, and indulged at such times in unconnected and silly talk that appeared to sound strangely to those around her, but no precise instance could be adduced and the incoherence of her utterance was very naturally explained by the untruths she sought to co-ordinate. She showed, on examination, such a connection and clearness of ideas as to leave no doubt as to the integrity of her reason and a perfect consciousness of her acts.

A man of 55 years, accused of rape, was represented to be a sufferer from mental exaltation at times. He was melancholy and retiring, but this was only his method of hiding methods by the aid of which he satisfied his passions. He presented in reality no signs of mental alienation, and was considered to be entirely responsible for his guilty acts.

A swindler, who, at the moment of his arrest, illegally wore several decorations, attempted to pass for insane, but his excuse was not deemed consistent. "His mother," said one of the witnesses, "considered him slightly insane, but I was never able to notice it." Another witness said: "It is thought by some that he suffered from mental disease, but I never believed it. He made his victim drunk, but remained sober himself." In fact, the examination held at the prisoner's house, and the explanation he offered, made it plainly apparent that his insanity was only pretended.

Simulated Insanity.—Let us now look at simulation properly speaking, at those cases where an impostor, either to escape merited punishment for a crime, or to secure a free living and life of idleness in an insane asylum, plays the *role* and accepts treatment as a lunatic, without foreseeing that such a ruse requires unusual skill and ability in order to prevent discovery, and with no fear of the horrible suffering to which he condemns himself under such circumstances. Simulated insanity under these conditions is rare, but its study, to the medico-legal expert, is one of such great interest that it is important to investigate its character with the most minute care. It is necessary to examine the various forms of simulated lunacy, and the character of the simulation; especially is this true in the absence of physical symptoms of insanity.

Forms of Feigned Insanity.—All forms of insanity are not equally available in simulation. There are those which by the particular ease with which they can be adopted are most tempting to impostors. These are, in the first place, those forms which are accompanied by striking manifestations used for the purpose of impressing the public—the noisy manifestations of lunacy. It is certain that acute mania, with its incoherence, its wild talk, its discon-

nected thoughts, its violence of gesture and words, its irrepressible loquacity, the generality of its delirium permitting all kinds of license to be used, can be adopted by those playing a lunatic part. But I will soon show that attempts to play this *role* are not as easy as one would be inclined to think.

Dementia is less easy to simulate. There is no longer a chance for exaggeration. It is necessary to shade the colors more finely by concealing the intelligence still present, and assuming mental inertia while the mind remains active. The shadows are, in reality, too difficult to detect in this form of mental weakness. I will say the same for idiocy and imbecility, and if you will recollect the characteristics of these original infirmities, which I have elsewhere indicated, you can understand, without the least trouble, why they offer no inducements to even the most impudent simulators. It has happened, however, that some impostors have not been deterred from feigning a physical and moral infirmity, a thing which requires an immense amount of perseverance, will power, and deceit. I wish to speak of deaf-mutes. Dr. E. Renaudin had in his asylum an individual who for three years passed for an imbecile and deaf mute, whose fraud was only discovered by accident, under the influence of the douche, which was being used for punishing violence. A more astonishing example still was that of the often quoted deaf-mute who forgot his part and recovered his speech on hearing his death penalty read.

Melancholy insanity and the stupid condition are the most frequent and difficult forms of simulated lunacy to discover. Isolation, stolidity, silence, are characteristics really not difficult to assume, and no matter how little control the simulator may have over himself, he wears a mask behind which it is not easy to penetrate. Seated upon the ground, in the corner of the asylum, with eyes drooping and hands clasped, the impostor may often for a long time baffle the investigations of an expert, and afford the least possible insight as to his real mental condition, although not completely disarming suspicion.

I will not speak of hysterical lunacy: it is deceit and feigning also; but both are here instructive to a certain degree, symptomatic of a rare affection, and cannot be included in the same category and studied from the same point of view as the voluntary simulation of the various forms of insanity by an individual otherwise healthy in mind.

The Behavior of Simulation.—We may say that feigned insanity is, to the eyes of the vulgar, more true than real lunacy; it is the theatrical insanity, that of disheveled hair, attitudes, gestures, strange costumes, songs, vociferations, animal cries, shrieks, dances, contortions, smiles and tears, fury, and other actions without number. This external appearance can only deceive superficial observers. So the most skillful simulators, who have received their education for the greatest part in the society of the insane, or from a

sojourn in lunatic asylums, do not indulge in such gross exaggerations or burlesque comedy; nevertheless they rarely forego the temptation to overdo the manifestations of intellectual disorder. They consider it necessary to keep up without relaxation a complete incoherence, with a perpetual confusion of such things, as names, persons, numbers, dates, days, etc. They consider, like the great philosophers, that a lunatic must have no consciousness of self, nor of his personality. In the famous case of Derozier, of which Dr. Morse has made such a beautiful and striking study, to the demand made as to his age, the impostor, who had hesitated, replied: "Two hundred and forty-five francs, thirty-five centimes:" as regarded his family, his brothers and children—"I have furnished them much money." On a second examination, Derozier was asked whether it was day, and replied: "It is night." On being questioned again as to his age, he replied: "I am king of Beaurais." When asked for his right hand, he invariable extended his left; when the left hand was asked for, he extended the right. Another impostor stated there were eleven hours in the week. A third simulator pretended not to recognize his most familiar friends; he spoke of his physician, whom he saw every day, as a female. All such swindlers act in different manners, but without leaving the circle of the absurd and impossible, never indulging in anything but the most shocking incoherence and the most ridiculous nonsense. That which is most significant, that which contributes an excellent and altogether medical sign of feigning, is the deficient connection between the most necessary and most constant symptoms of the type of lunacy adopted by the simulator. It is a fact that cannot be denied, even by those who may have made a special study of insanity, that there are certain signs that are never found together in the same subject; and that there is an incompatibility between the phenomena which belong to such forms of lunacy. Thus, one will not find in the idiot, or imbecile, any intermittence, nor even a momentary consciousness of his position. Stupidity cannot aid the answers made by a person suffering from dementia. The artificial expression of dullness exhibited by a person laboring under melancholia, does not permit the least ray of intelligence to light up the face, and there is not the faintest suspicion that a question asked has been well understood. There is one irreconcilability, if we may be permitted to use such a term, that is not suspected by the vast majority of simulators. They know that delirium is not always continued, they think the same of dementia and of imbecility, and fall into such discord as to awaken the attention of the expert physician, so that a single contradiction alone may dash the mask from the face of the swindler. The expert can then readily read the truth in the eyes that cannot succeed in hiding intelligence, and in the face which cannot remain immovable and impenetrable.

An habitual habit in those who feign insanity is to suddenly change the

attitude, the face, the answers, when finding themselves closely observed, as for instance when brought into the presence of a physician, or in appearing before a magistrate and jury. Derozier, who played chess with his companions, whenever he saw a keeper pass, disarranged the play by pushing the pieces at random and irregularly. Another impostor, who had behaved with decorum previously, when brought into court performed an act of nature in the full presence of the judge and jury. Among some simulators the memory, which had not appeared to be affected before trial, became faulty; or delirium and incoherence were manifested suddenly, and with the most flagrant exaggeration.

Methods of Discovering Feigned Insanity.—I will now retrace all of the principal features of feigned insanity, and show how the simulator conducts himself; for it is important that the medical expert should know the methods by which impostors may be recognized and exposed; not that there is any one particular method to follow in such investigation, but there are nevertheless some special rules to add to those which are, in a general manner, applicable to the medico-legal determination of simulation.

A first principle, never to be neglected, and which in no case is more appropriate than in suspected cases of feigned insanity, is, *refrain from expressing any opinion until the patient has been subjected to prolonged, repeated, and persevering observation.* Nothing in an examination is more necessary or indispensable. Such observations should be made at all times, if not directly, at least indirectly, by persons familiar with the habits of the insane. For this very useful and important reason, the person suspected should always be transferred to an insane asylum before a positive opinion is given. This is especially the true procedure in those cases where the supposed impostor is confined to jail, where methods of investigation are less surely and less easily applicable. The time during which the pretended lunatic is submitted to this kind of quarantine of observation, is not lost for the manifestation of the truth; in fact, it may be evidenced by the mere contact and presence of the insane, for the impostor changes and suddenly modifies his methods of simulation, thus showing how inconsistent and insincere his symptoms are. On the other hand, the impostor is often badly frightened at the thought of remaining among real lunatics, and abandons the very arduous and painful *role*, on account of the ordeal to which he is submitted.

At this point I boldly affirm that I cannot admit more for insanity than for other simulated affections, and that I denounce all those unnecessary experiments sometimes thought to be essential in cases of supposed simulation, even in those cases where feigning is most justly expected. I repudiate in a positive manner and to the best of my ability, and also ask my pupils and those who use my works as authority to do likewise, those practices which directly or indirectly tend to injure patients submitted for expert examination.

directly or indirectly tend to injure patients submitted for expert examination. For the expert physician has no right to inflict bodily suffering, or expose to danger, a suspected person no matter how great may be the interests of justice in discovering the truth of the case. Chloroform, the douche, burning with hot iron, stupefying or narcotic poisons, such as belladonna, haschhisch or opium, which may so powerfully modify sensibility and the play of the intellectual function—results awaited in order to make a simulating lunatic speak, a supposed idiot reason, or a pretended maniac confess—all methods which cannot be used without inconvenience to health or risk to life, should be sternly banished from the practice of the medico-legal expert. The true expert should be contented to appeal to his experience, and should apply all his sagacity to the service of patient observation; a procedure that will most often lead to a positive conclusion; that is to say, to a certainty in appreciating those processes of simulation which I have previously indicated.

The expert must not lay aside the rules applicable to the diagnosis of insanity, and limit himself to investigating those precise signs which permit the classification of the individual in such and such a group, connecting each species of insanity with such and such a clearly defined type. He need have no dread, when in the presence of a simulator, of danger from a too close categorisation; for one has no business in these cases either with too delicate shades or too indefinitely marked characteristics. It is the contrary rather that takes place, and the problem always returns, in the case of simulation as in the case of real insanity, to these terms, if not very simple at least well defined, to-wit: *determine whether the mental condition is healthy or diseased.*

For this purpose the expert must proceed, with more care than ever, to investigate the moral and physical cause, original and hereditary or acquired, which might explain the development of the insanity, the form it has assumed, and the course it has followed, and also submit to severe analysis the different symptoms of intellectual trouble, their nature, relations and connections.

It is no less important to direct our examination towards the physical symptoms we are accustomed to meet among the insane, and which the simulator is altogether unable to reproduce. In the first place, the insomnia which is rarely missing in acute forms of insanity, cannot be supported by an impostor already fatigued with the efforts required to keep up the part of a simulator. So we see the feigner only too happy to drop his *role* and seek comfort and refuge in sleep—a sleep most commonly profound—so that the first moment of waking, when his ideas though still confused are not controlled by a false delirium, will afford a proper time to observe and surprise the simulation. The appetite among simulators does not offer the irregu-

larity and caprices that are usually met among the truly insane. All that which can bring diversion to the principal work of simulation, is seized with avidity by an impostor, and meantime affords a natural occasion for relaxation which no simulator will allow to slip. The organic functions, digestion, respiration, and circulation, remain perfectly intact in the case of an impostor. Some simulators have been known to essay the reproduction of certain troubles of sensibility, or motility, observed so often in true insanity; as, for instance, anesthesia, paralysis of the tongue or limbs, or palsy. But there are complications which, far from assuring success, have more often the effect of compromising and rendering simulation more difficult; in fact, furnishing the expert a new key to discovery. Finally, the external appearance, the general aspect, are very rarely reproduced with exactitude by those who feign insanity; as, for instance, the physiognomy, the attitude, and the expression of a real lunatic. I boldly affirm that to a skilled expert these signs are those that can be least perfectly imitated, and consequently are least calculated to deceive. It is certainly easy for an impostor to walk with a quick step, stop suddenly, with nose high in air and eyes fixed on the sky, and mutter to himself; as it is likewise easy to act a part in rags or an extravagant costume, but these are only vulgar means which almost always fail, owing to an exaggeration of action, and especially because such action is poorly adapted to the actor; that is to say, to the type of insanity chosen by the simulator.

Dr. Laurent, in a very excellent study has insisted with much wisdom on the particular characteristics offered by an impostor's facial expression. "It is," says Dr. L. "furtive, unsteady, sly. Its form evidences a condition of force, a striking and sufficient discord. The criminal impostor cannot give his features the frightened and excited expressions of the maniac. We recognize only brazen impudence, and not mental aberration. The simulator can not reproduce the true indifferent expression, or weak minded visage, of dementia or paralysis, the vacant stare of the idiot, or the proud and haughty aspect of the mono-maniac. He cannot conceal the attention he bestows on all the words and movements of those who he knows are intrusted to watch his gestures and words; most often he lowers his eyes, as if fearing his expression might betray him."

But there are some particular precepts, exceedingly necessary for the medical expert to remember, as regards simulated insanity. Ruse and dissimulation are characteristic and almost constant traits of the true lunatic, and it is best always to be on one's guard not to confound the simulation of the true lunatic with that of the impostor. But precisely as the first take care to defend themselves from any imputation of insanity, those of the second part strive to exhibit their pretended lunacy. The true lunatic endeavors to excuse all the perturbations noticed in his intellectual functions, and does

not wish to be considered insane; while the impostor endeavors to impress all with the fact of his mental aberration, and never plays the *role* of lunatic better than when in the presence of those who are to judge of his conduct; as, for instance, before a magistrate or physician from whom the real lunatic endeavors to carefully conceal his delirious conceptions.

It is still necessary, in order to appreciate real insanity from simulation, to take into consideration the most serious of three circumstances which are noticeable principally among individuals charged with grave criminal offenses; that is to say, in delicate and intricate cases.

The first consists in the fact that insanity may be developed in a short time after imprisonment, or even at the very moment of the crime which has brought about incarceration, although the criminal act itself may have been perpetrated in a healthy condition of mind. I do not allude here to the methods of confinement in cells, for I have already stated, many years since, and I still persist in thinking, that such a system of imprisonment does not usually produce the effect attributed to it after the mere superficial observations of the mental conditions of prisoners. It is not often that we see insanity developed at the commencement of incarceration, but it is certain that mental aberration sometimes attacks a prisoner at the first moments of crime, favored by a predisposition the least questionable, and produced by the moral shock which the crime caused, together with the fear of punishment. This is a point I wish to strongly impress on those experts who seek to determine the truth regarding real or feigned insanity.

The second circumstance, which no less merits attention, is purely pathological. I speak of the changes which may occur in certain forms of insanity and the natural and spontaneous modifications that go on in the intellectual and moral disposition of those attacked. The expert will run the risk of committing the most serious errors if he mistakes the nature of these changes, and attributes them to the studious and voluntary attempts of a simulator. It is sufficient for me, including all those experts having experience with lunacy, to cite that double form of insanity which may produce, by the simple evolution of its fatal circle, phenomena in appearance altogether unattended by mental alienation; those attacks of periodical mania, where the acute delirium sometimes exhibits itself under such conditions as might lead to the belief that the patient is feigning. In all such cases, the attentive study of antecedents, and of the elements proper to each form of insanity and their particular progress, will permit us to avoid all confusion.

Is it necessary for us to admit that true lunatics may sometimes feign a form of insanity other than that by which they are really affected? Bailarger, Vingtrenier, and Griesinger state that they have observed such cases.

Finally, there is a last point of great delicacy, upon which it is necessary to insist before concluding. This is that simulation itself, however briefly it

may be kept up, finishes, by exercising, an incontestible influence upon the moral and physical condition of those who attempt playing such parts. This is found to be the case even when the simulation of purely physical maladies is essayed; for we see phenomena developed beyond the control of the will, changes in the organism itself; for example, when those who feign paralysis of a limb give the member absolute rest, atrophy of the muscles is induced. It is the same as regards the intellectual faculties, for the imitated mental incoherence, the faulty exercise of the mind, may in the course of time obliterate and falsify the judgment, bring on real mental feebleness, and totally pervert the intelligence and sentiments. It is in moral as in physical attitudes, certain manifestations provoked and simulated at the commencement, become to a certain degree natural, and are instinctively produced without the participation of the will. Those who feign blindness, by keeping their eyes closed for a number of years, are found to be incapable of tolerating the light or seeing; in the same manner as those who feign mutism, and the immobility of the idiot for years, end by becoming really and completely stupid. There is not one among all those who, after having simulated insanity have been discovered, or have given up the attempt of their own accord, have not admitted that they felt themselves becoming insane and that they would not undergo the torture again to save their necks from the hangman. "You cannot appreciate what I have suffered!" cried the unmasked impostor Derozier to the expert Dr. Morse. "I thought I should really go insane, and I still have more dread of becoming a lunatic than of going to the galley." This feeling, really sincere among a majority of simulators, may be usefully put to profit by the medico-legal expert, and become a valuable aid in the discovery of feigned insanity.

SELECTIONS.

SURGERY.

THE TREATMENT OF CLUB-FOOT WITH APPARATUS.—Dr. James S. Green, of New York, contributes to the November number of the "New York Medical Journal and Obstetrical Review" an article in which he argues that a great majority of the most intractable forms of club-foot may be treated successfully without the use of the knife. To effect the purpose of safe,

comfortable, and certain reduction of chronic club-foot by mechanical means he remarks, the instrument must perform the following functions: 1. It must effect by extension *the separation* of the articular surfaces of the bones involved exactly in the position in which they are presented by the deformity. The extension should be so complete that the synovial surfaces of the tarsal bones will slide *over* and *not upon* each other when the foot is twisted into its normal position. (This condition being obtained of itself reduces to a minimum the amount of force necessary to be exerted in moving the bones, which are thereby not jammed against each other, the synovial membrane and the cartilages injured, and ulceration of the soft parts made imminent.) 2. It should produce the *gradual* reduction of the foot to a normal position by continuous stretching, acting exactly in an opposite direction to the lines of the deformity.

In talipes equino-varus (the most common form) it should flex the foot, thereby overcoming the contraction of the gastrocnemius and soleus muscles, while at the same time it should abduct the foot, reducing the rigidity of the tibialis anticus and tibialis posticus muscles. It should stretch the plantar fascia, after overcoming the tendo Achillis and during the reduction of the tibial muscles. Withal, the instrument should be light in weight, portable, and easily worn, so that the patient may assist the cure by walking upon the foot which is being gradually extended and drawn toward its normal position. It should be so constructed that, as the opposing tissues yield to the applied forces, the advantage gained, be it ever so little, can be easily seized and retained. The "compound club-foot twister," an instrument employed by the author and his associate, Dr. C. F. Stillman, is described as being so constructed as to twist the anterior position of the foot on the posterior at the medio tarsal joint, and also to gradually and painlessly alter the angle of the foot with the leg at the ankle joint. It consists of a local extender, provided with a slotted arc for graduated movements, placed each side of the ankle joint, and another placed in front of the arch of the foot. Below these are attached to a flexible felt or leather sole, on which the foot is firmly fastened by bandages; and above they are connected to metal terminal plates, which are bound down to the leg by some immobile dressing. This splint allows the foot to be twisted back into shape without pain, as it provides a local extension which relieves the parts from strain and attrition during the twisting, and also allows the patient to walk without interfering with the action of the instrument, the foot being completely under the control of the surgeon. The instrument and dressing used in a case related weighed thirteen ounces.

NERVE-STRETCHING has been abandoned by Billroth after a fair trial. It does not seem to be making a favorable impression in Vienna.—*Louisville Med. News.*

A METHOD OF TREATING SUBCUTANEOUS NEVI.—About a year ago a child aged nine months was brought to me with a nevus about three-quarters of an inch in diameter, filling up the fossa on the left side of the nose. The swelling was entirely subcutaneous, and it was evident that none of the applications which cure the superficial form of the disease would be of any use. The gold needle usually employed in such cases was connected with a battery and introduced into the tumor, but the restlessness of the child (his eye being endangered) made me abandon it. Two lengths of No. 24 silver wire were then passed through the middle part of the swelling, parallel to each other and about a quarter of an inch apart. The zinc and carbon of a Bunsen cell (quart size) were then connected with the ends of each wire separately. The result was great heat in the wire during the short period, one or two seconds, of connection. The ends of the wires were then tightly twisted together, protected by being covered with lint and plaster, and left for the next application, which took place a week later. The current was applied three times altogether. The wires were removed after the third galvanization and no further treatment was needed. The nevus is now hardly perceptible.

This mode of using the galvanic current in the deeper nevi appears to me to be recommended by its simplicity and freedom from danger. There is less pain than is caused by the usual introduction of the needles at each operation, and a single cell (bichromate, Grove's or Bunsen's) is sufficient, the only resistance being the fine silver wire.—*Carey Coombs, M. D., in London Lancet.*

DEPILATORY POMADE :

R.	Sodii carbon.....	3j.
	Quicklime.....	3ss.
	Charcoal powder.....	gr. viij.
	Glycerine.....	f. 3j.
	Lard.....	3 viij.
	M.	

After applying this to the affected parts for ten or twelve days, the skin takes a rose tint, and the hairs may be drawn out without pain.

OPERATIVE ASSISTANCE IN INFANTILE PARALYSIS.—Some cases recently operated on by Prof. Albert have excited a good deal of interest. Struck by the fact that many subjects of infantile paralysis are condemned to the lifelong use of more or less complicated apparatus to compensate for the loss of rigidity in the lower limbs, and that the poor cannot get such instruments, he has attempted to increase the use of the legs by operation. He excises the knee and ankle joints, and thus obtains bony ankylosis between the femur and tibia, and tibia, fibula, and astragalus. The rigid lower limbs in walking

are swung forward by the abductor and great flexor muscles of the hip-joint, which generally retain or recover their power. This treatment has already been carried out in four cases, and a fifth is now preparing for operation.—*Lancet*.

WOUNDS OF THE LUNG.—In the *Lancet*, October, 1881, are recorded two interesting cases of recovery from severe wounds of the lung. Surgeon-Major T. M. O'Farrell's case was that of a porter. A sword-bayonet entered the right axilla, having first penetrated the muscles of the arm. Immediately his mouth filled with blood, and he felt very faint. When seen, twenty minutes afterwards, he was very faint, and complained of great oppression about the chest; his pulse could scarcely be felt, and now and again he gave a short cough, when a stream of blood issued from his mouth. In nineteen days the man was sufficiently recovered to walk about. The case is a good instance of the comparative impunity with which a young and healthy man may receive injuries of so delicate and complex an organ as the lung. Dr. Holmes' case was very singular. A miner, standing at the bottom of a shaft 225 feet deep, was wounded by a drill that fell from above. The drill measured three feet in length, and weighed eight pounds and a half. The bit of the drill struck his back near the superior angle of the left scapula, emerging in front, on a line with the left nipple, fracturing the sixth rib. The wound was eight inches and a half in length. The drill passed through the man's body almost up to its head. The patient called upon some of his comrades to pull out the foreign body, and two men laying hold forcibly extracted it, considerably tearing, in the process, the lung and flesh. When admitted into the hospital the patient was bleeding freely, and in a fainting condition. Air at every respiration passed, with a gush of blood from each aperture. Sixteen days after the wound, the patient walked out of the hospital to see some street demonstration, and in two months he felt nearly as strong as ever. The lung, however, had shrunk to about two-thirds its natural size.—*Hosp. Gazette*.

CARTHAGO EST DELENDA—THE DEATH OF THE CARBOLIC CRAZE!—To every thoughtful man it must be perfectly humiliating, from the scientific standpoint, to reflect on the surgical fanfaronade which, for the past few years, agitated not only the profession, but the public, in connection with carbolic acid, and now to read in the editorial columns of a contemporary, "We may say that the day of carbolic acid is over." . . . "The spray has been abandoned by many surgeons, and even Mr. Lister has spoken in qualified terms of its necessity; and had we to prophesy, instead of to record accomplished facts, we might venture to predict an early abandonment of this cumbrous addition to a surgeon's armamentarium." All this is

precisely what all sensible men knew sufficiently well to be inevitable. But what of the great "cures" that have been accomplished by means of carbolic acid? What of the children who have first entered the "vale of tears" through its incense? What of the ephemeral reputations based on this illusory theory? What of the numerous papers which have appeared in our journals from so many incapable of forming correct judgments, but anxious as to the chance of advertising? We are getting back to where we were before the famous carbolic acid theory was propounded; but medical science cannot fail to suffer from such insensate outbreaks of surgical fashion, nor can the contempt of all intelligent members of the profession be withheld therefrom.—*Med. Press and Circular.*

HOT WATER IN THE TREATMENT OF HEMORRHOIDS.—Lanpowski suggests hot sitz-baths in bleeding piles, together with enemata of hot water. These not only check the bleeding, but diminish the size of the turgescient tumors to a marked degree. In ordinary cases three sitz-baths per diem may be employed. In bleeding piles the baths should be more frequent, and the enemata should be given as hot as the patient can bear (usually about 104°).

MEDICINE.

METHODS OF ADMINISTERING CHLORAL HYDRATE.—Dr. Kane, in the *Chicago Medical Journal*, makes some interesting suggestions respecting the use of chloral. When administering chloral we should be certain that it is pure. Bouchet gives the following test as being sufficiently reliable for roughly determining its purity:—"By taking chloral in a chrystallised, needle-shaped, or snow-like mass, it will, in all probability, be acceptable; but to be certain of its purity it must be tested with a concentrated solution of potash. If the chloral is pure it will color the potash solution possibly a very light yellow, and emit an unmistakable odor of chloroform. If it is absolutely pure the solution will remain uncolored. If a brown color shows itself and there is given forth the odor of chloroform mixed with chloratic vapors, or gases of an acrid and disagreeable smell, it is impure." It should be administered in the majority of cases by the mouth or rectum. If given hypodermically it is apt to produce deep-seated and superficial inflammation and abscesses. The intra-venous method is to be used only in the rarest instances, and is always dangerous. When chloral is given by the mouth it should always be in solution. I prefer a simple aqueous solution of ten grains to the drachm, and order separately *syp. tolut.*, and let patient add a drachm or two to each dose of the chloral solution at time of taking; and to overcome the irritating effect of the chloral upon the buccal, pharyn-

geal, and gastric mucous membrane, have patient eat a little something, say a cracker, before taking the dose.

Chloral hydrate is peculiar in that it acts with about the same rapidity and intensity when given by the rectum as when given by the mouth. It has been found of great advantage to give it in this way, in two classes of cases:—1st. Those where, owing to some spasmodic or convulsive affection, it is impossible, or very troublesome, to give it by the mouth. 2d. In cases where, from inflammatory affections of stomach or throat, it is not deemed advisable to give this drug by the mouth owing to the possibility of causing local irritant action. When given as an enema, in pure water, it often causes irritation of the mucous membrane of the rectum; to overcome this it may be beaten up with raw eggs and milk. It is best exhibited, however, as a suppository, always bearing in mind that as it is a solvent of fats and cocoa butter, the usual vehicles for suppositories will not answer unless used in connection with white wax or spermaceti.—*Detroit Lancet*.

Da Costa considers ergotine the best remedy for the night-sweats of phthisis—two grs. three or four time a day. It is less prompt than atropia, but it is free from any unpleasant after effects.

HICCOUGH CURED BY COMPRESSION,—A case is cited from a French journal, in which hiccough which had been “incessant for fifty days,” was cured in five minutes by a powerful compression over the epigastrium. All other conceivable means had failed.

NITRE TABLETS FOR ASTHMA AND INSOMNIA.—Dr. Wm. Murrell, in the *British Medical Journal*, writes: There can be no question as to the value of fuming inhalations in the treatment of asthma. The ordinary nitre-paper often fails, because it is not strong enough. For some time past I have been in the habit of using very thick and strong nitre-papers, which may be called “nitre-tablets.” They contain both chlorate and nitrate of potash. Each consists of six pieces of white blotting paper, about six inches square, and they are made by dipping them into a hot saturated solution of nitre and chlorate of potash. Before the pieces are quite dry, they may be sprinkled with Friar’s balsam, spirit of camphor, tincture of sumbul, or some aromatic. The nitre-paper so prepared is as thick as cardboard, each piece consisting of six pieces of blotting-paper, closely adherent, and covered all over with crystals of saltpetre and chlorate of potash. The door and windows having been closed, the tablet is placed on a fire-shovel or piece of metal of some kind, and folded down the middle, so as to make it like a tent or the cover of a book. When lighted at each end it burns very quickly, throwing out a flame often four or five inches long, and giving rise to dense volumes of smoke. The

asthmatic patient almost immediately obtains relief, and drops off into a quiet slumber, from which he awakes refreshed. These tablets often succeed when the ordinary nitre-papers do no good. They nearly always induce sleep, and I have used them with success in cases of insomnia when most of the ordinary remedies have failed. Large pastils composed of equal parts of nitre and lycopodium are also useful in asthma.—*Chemist and Druggist.*

REVIEWS AND BOOK NOTICES.

Prices are always inserted when furnished by the publisher, or when obtainable from the bookseller.

A System of Surgery, Theoretical and Practical. In treatises by various authors. Edited by T. Holmes, M. A. Cantab, Surgeon and Lecturer on Surgery at St. George's Hospital, etc. First American from second English Edition, thoroughly revised and much enlarged. By John H. Packard, M. D., etc., assisted by a large corps of the most eminent American surgeons. In three volumes. Vol. II. Philadelphia: Henry C. Lea's Son & Co. 1881.

The first volume of this system was noticed some months ago. This one treats of the Diseases of the Organs of Special Sense; of the Circulatory System—including an entirely new section on the injuries and diseases of the Absorbent System, by S. C. Busey, of Washington; of the Digestive Tract, and of the Genito-Urinary Organs. The American revisers are: on the Eye, Geo. C. Harlan; Ear, Chas. H. Burnett; Nose, J. S. Cohen; Tongue, Chas. McBurney; Veins and Arteries, Lewis A. Stimson; Mouth, J. W. White; Teeth, James Truman, D. D. S.; Intestines, J. H. C. Simes; Rectum and Hernia, John H. Packard; Urinary Organs, Calculi, Lithotomy and Lithotripsy, Edward L. Keyes; Male Generative Organs and Gonorrhoea, J. W. White; Surgical Diseases of Women, A. J. C. Skene.

The copious additions made by the revisers, serve to fully carry out the original idea of the publishers—to Americanize the book. Each reviser is an adept in the subject assigned him, and the work has in consequence been admirably done.

The Anatomist, being a complete description of the anatomy of the human body, intended for the use of students preparing for examination at the Royal College of Surgeons and other medical bodies. Second Edition, improved and enlarged by the addition of 171 wood engravings. By M. W. Hilles, formerly lecturer on anatomy and physiology at the Westminster Hospital school of medicine, etc. New York: G. D. Putnam's Sons. 1881. 16mo. Pp. 360. Cloth.

This is very like other works of its kind. It possesses the advantage of being thoroughly illustrated, although occasionally the cuts are so small as to diminish their value.

That these books always sell well, is no particular recommendation for them.

The Student's Manual of Venereal Diseases, by Berkeley Hill and Arthur Cooper. Second Edition. New York: Wm. Wood & Co. 1881. 8vo. Pp. 62. Paper. Price, 10 cents.

We need not allude to the book itself, as this is sufficiently well known, but rather to the style and *price*. The type is large and clear, and the paper of good quality.

Transactions Michigan State Medical Society for the year 1881.

We have here seven papers of which five are written by Detroit Professors.

President Thomas' address is on the subject of Civil Malpractice, which is well presented although nothing new is developed.

Prof. Lundy has a paper on the treatment of acute Glaucoma by Eserine, in which he reports *one* successful case.

Prof. Reynolds presents an illy prepared paper, less than a page in length, with the curiously mixed title—"Treatment at Birth in Congenital Club-Foot."

Prof. Lyster's paper consists of Clinical Notes on a Case of Pneumonia. The monotony of the printed page is diversified by no less than thirteen prescription formulæ—not one of which is correctly written. An analysis of the treatment reveals that the unfortunate young man took: sulphate of quinine, opium, rosemary, cinnamon, cloves, nutmeg, red saunders, lavender, valerian, chloroform, syrup, svapnia (!), camphor, spir. Mindereri, gelseminum, Dover's powder, veratrum viride, whiskey, ammonia muriate, quinia muriate, cantharides (externally), chlorinated tincture of iron, sage tea, belladonna (externally), ammonium iodide, sanguinaria, cinchona, orange peel, serpentaria, belladonna, hyoscyamus, conium, sulphuric acid, ginger, taraxicum, iodine (externally), claret wine, catawba wine, potassium iodide, codia, yerba santa, ipecac, prunus Virginiana, morphia muriate, coca, cod

liver oil, maltine wine, and extract of malt. The patient was fortunately young and possessed of a vigorous constitution; and so escaped.

Prof. Leonard ("C. Henri") reports a case of uterine retroflexion, treated by "*my* new uterine reposit^r," and a "*bolus*" of cotton, "*soaked in my glycerole of tannin dressing.*"

Prof. Smith's paper, on Granular Lids, contains nothing new whatever.

Dr. Burr, assistant physician in the Pontiac Insane Asylum, reports a number of cases of epilepsy treated by *Cocculus Indicus*. He uses one or two drops of the fluid extract thrice daily. His conclusion is that those patients, in good bodily health, whose seizures are accompanied by maniacal excitement, seem to be the ones most likely to receive benefit.

Dr. Brown, of Monroe, reports an interesting case of Intra-peritoneal Hematocele.

The report of one committee deserves a passing notice; namely, the committee to which was referred the matter of so changing the constitution of the Society as to make it purely a delegate body. The report is adverse to the change, on the ground that the Northern Peninsula has no county medical society whatever, while in the Southern Peninsula the societies are limited to the extreme southern portion; so that the proposed change would practically bar out all the upper peninsula, and two-thirds of the lower. The opinion of the committee would seem, therefore, to be a very natural and judicious one.

The State of Michigan has no cause to be proud of this volume of Transactions of its representative Medical Society.

The Nurse and Mother. A Manual for the Guidance of Monthly Nurses and Mothers, comprising instructions in regard to pregnancy and preparation for childbirth; with minute directions as to care during confinement, and for the management and feeding of infants. By Walter Coles, M. D., Consulting Surgeon to St. Ann's Lying-in Asylum, St. Louis; Member of the St. Louis Obstetrical and Gynecological Society, &c., &c.: J. H. Chambers & Co., Chicago, Ill.; St. Louis, Mo.; Atlanta, Ga., 1881. 8vo. pp. 153.

The average monthly nurse of to-day differs but little from her prototype, the "Old Granny," of a former period. She is far too often a "queer mixture" of meddlesome ignorance, self-importance, and absurd superstitions. It is rare that one meets in the lying-in chamber a nurse who is able to pass a catheter, properly administer a rectal or vaginal injection, or who can understand her relation to the physician in attendance. It will be a happy day for physician and mother when monthly nurses possess the intelligence and special training fitting them for the responsible duties of their vocation. The little tract before us seeks to impart that information, without which no one can render intelligent and efficient assistance in the lying-in room.

We can strongly endorse Dr. Coles' Manual. It is written in a pleasant style, and contains a vast amount of information, valuable alike to mother and nurse.

We would, however, protest against trusting the nurse with the administration of anesthetics to the extent the author does. While it is true that chloroform accidents are rare in midwifery practice, it is unwise to push the "special immunity" idea too far. We should also unhesitatingly condemn the following practice: on page 82, our author says: "In some instances the doctor deems it necessary to wash out the cavity of the womb; this operation should always be performed under his immediate supervision." Intra-uterine manipulations, of whatever kind, come within the province of the physician, not that of the nurse.

While highly endorsing the general character of the book, we may sadly ask, *Cui bono?* Dr. Coles' Manual contains nothing new to the professional reader, and will probably never reach the class for whom it was written and whom it would largely benefit. Perhaps it would be the part of wisdom, at this gift-making season, for every physician to present a copy to those nurses whom he is accustomed to meet in his obstetric practice. Both giver and receiver would thereby be benefited.

W. J. C.

The Therapeutics of Gynecology and Obstetrics, comprising the Medical, Dietetic and Hygienic Treatment of Diseases of Women. Second edition. Thoroughly revised and greatly enlarged. Edited by Wm. B. Atkinson, M. D. Philadelphia: D. G. Brinton, 1881. 8vo. pp. 571.

The appearance of a second edition so soon after the first sufficiently indicates the favorable reception which has been accorded Dr. Atkinson's work.

The text of the present edition has not only been carefully revised, but nearly two hundred pages of new matter have been added. The new matter includes discussions on the Use of Antiseptics in Labor, Disorders of the Eye in Pregnancy, Placenta, Previa, and other subjects. The book is not a mere collection of formula, but each chapter is prefaced with a synopsis of diagnostic points, stating briefly but clearly the distinctive features of the diseases considered in the chapter.

In its present form it very truthfully reflects the approved therapeutic methods of the most eminent authorities in the department of medicine of which it treats.

Dr. Atkinson's Therapeutics is therefore a most excellent one, and will prove "a refuge and strength" to the busy practitioner in emergencies.

It can not supersede the more systematic works on Diseases of Women and Obstetrics which should be found in every library. Just so far as it furnishes an excuse for lazy practitioners to neglect the standard authorities on these subjects, it will do harm.

W. J. C.

Nervous Diseases, Their Description and Treatment. A Manual for Students and Practitioners of Medicine. By Allen McLane Hamilton, M. D. One of the attending physicians at the Hospital for Epileptics and Paralytics, at the Hudson River State Hospital for the Insane, etc., etc. Second edition, revised and enlarged, with seventy-two illustrations. Philadelphia: H. C. Lea's Son & Co. 1881.

To the first edition of this book was accorded a reception very flattering to its author. There has been added to it about one hundred pages of new matter as needed to adequately note the progress of neurological science. The chapters dealing with the subject of *localization* have been improved and enlarged. The diseases of the lateral columns of the cord, about which hangs so much obscurity, have received close study from the author, and his conclusions are clearly expressed.

Dr. Hamilton's book is of a convenient size for a manual, while its scope is sufficiently ample for all practical purposes. It is cordially commended both to students and practitioners.

Essentials of the Principles and Practice of Medicine. A hand-book for students and practitioners. By Henry Hartshorne, M. D., lately Professor of Hygiene in the University of Pennsylvania, etc., etc. Fifth edition, thoroughly revised and improved, with 144 illustrations. Philadelphia: Henry C. Lea's Son & Co. 1881. Cloth. 8vo. Pp. 670. Price, \$2.75.

This hand-book for the student is somewhat of the nature of a concentrated extract. It is hence of value chiefly to those who, while attending lectures, are compelled to take their mental medical pabulum in as condensed a shape as possible. Practitioners, and students with more leisure, will hardly find it to meet their wants.

The work of compression has been well done, and there is an immense amount of information contained in this work.

Index Catalogue of the Library of the Surgeon-General's Office, U. S. A. Compiled by Dr. J. S. Billings. Vol. II. Berlioz-Cholas. Pp. 990. Washington: Government Printing Office. 1881.

The Index Catalogue is a fitting testimonial to the energy and industry of Dr. Billings, whose labor in compiling it has been a labor of love. The second volume, now before us, contains, in alphabetical order, 11,550 subject-titles of separate books and pamphlets, and 37,310 titles of articles in periodicals. A better idea of the practical value of the catalogue may be obtained from the fact, that in the present volume, 67 pages are occupied by a mere enumeration of writings on the Blood; 81 by those on the Brain; 24 on the Bones; 37 on the Bladder; 35 on Calculus; 25 on Cancer; 23 on Cataract, and 31 on the Chest.

Lectures on Electricity (Dynamic and Franklinic), in Its Relations to Medicine and Surgery. By A. D. Rockwell, M. D., Electro-therapeutist to the New York State Woman's Hospital, etc. New York: William Wood & Co. 1881.

These lectures appeared first in the *Virginia Medical Monthly*. While the practical therapeutic applications of electricity are discussed sufficiently in this work, electro-physics or electro-physiology are also included in the author's range, though rather as a summary than an instructive treatise.

The tonic and soothing virtues of general faradization are dwelt upon with emphasis. The Franklinic revival gets little help from the author. Brief mention is made of the induction balance, and galvanic accumulator.

The book is well written, is gotten out in very neat style, and is profusely illustrated.

The Science of Art and Midwifery. By William Thompson Lusk, A. M., M. D., Professor of Obstetrics and Diseases of Women and Children in the Bellevue Hospital Medical College; Consulting Physician to the Maternity Hospital, etc., etc. With numerous illustrations. New York: D. Appleton & Co. Columbus; Geo. W. Gleason. 1882. Pp. 687. Cloth. \$5. Leather, \$6.

This treatise is of a decidedly modern type. The author aims to show that with advancing knowledge the art of midwifery has ceased to rest upon empirical rules, and is already, with rare exceptions, the natural outcome of scientific principles. The description of the development of the ovum and its changes in the uterus is very thorough and complete, while the admirable manner in which the chapters on the art of successful delivery are written constitutes one of the best features of the book. Nothing which it is important for the practitioner to know is lost sight of in the directions given for managing labor of all kinds, as well as accidents and abortions. Copious references are given to native and foreign authors for all important statements made, so that any one may refer whenever desired for confirmation and further information to these authorities. We know of no work which can be more conscientiously recommended to students and physicians.

The Opium Habit and Alchohoism. A treatise on the habit of Opium and its Compounds: Alcohol; Chloral; Chloroform; Bromide Potassium, and Cannabis Indica, including their Therapeutical Indication, with suggestions for Treating Various Painful Complications. By Dr. Fred Herman Hubbard. New York: A. S. Barnes & Co. 1881.

The paper is excellent in this book, and the binding very neat; but here all praise must abruptly cease. The type is worn out, and the press-work poor,

The object of the author in writing the book seems to have been to advertise himself. His spelling is bad, his grammar worse, his Latin worst; while the matter itself is eminently unscientific and valueless, and serves to reveal the ignorance and conceit of the author. For example, he explains the thirst that opium users experience, by saying that the "Opium superinduces a thickened state of the fibrin and brings about an accumulation of effete matter, which renders functional action through the medulla oblongata slow and laborious, and creates a demand for water by drying up the mucous coats of the mouth," etc.

The author treats by gradually reducing the opium and substituting other narcotics and stimulants to relieve the craving.

New Journal—The American Medical Digest: New York; Campbell & Co., 21 Park Row. Pp. 48; Price \$3.00. Editor, John C. Lester, M. D.

This journal seems in its matter closely fashioned after the St. Louis *Brief*, and adds to its olla-podrida everything it can find commencing with the mystic "R." The names of Skene, Mathewson, Sturgis, Fox and Shaw, are appended as "contributors," but we fail to find any contributions from any of them, while the abstracts themselves seem to be all second-hand. The paper is good, and the type and press-work tolerable.

SOCIETY PROCEEDINGS.

MEDICAL ASSOCIATION OF DELAWARE COUNTY, OHIO, JANUARY 10, 1882.

The Association was called to order by President Dr. F. W. Morrison.

Members present, Drs. Welch, Cherry, Westbrook, Morrison, McDowell, A. W. Dumm, White, Constant, Hedges, Ropp, Hughs, Mercer, Keefer, S. C. Dumm, McCann, Crickard, McIntire, Coomes, Richards, and Clute.

Visitors, Dr. Goldrich of Delaware, and Dr. W. E. Benton, of Little Sandusky.

This being the annual meeting the election of officers for the year 1882 was held, which resulted as follows:

President, Dr. W. F. Ropp; Vice President, Dr. J. W. N. Vogt; Secre-

tary, Dr. W. F. Clute; Cor. Secretary, Dr. A. H. Keefer; Treasurer, Dr. J. M. Cherry; Librarian, Dr. F. W. Morrison.

Dr. A. W. Dumm read an interesting paper on Rheumatism.

Dr. McDowell said he was not enthusiastic upon specific remedies in any disease, but thinks salicylic acid a specific for rheumatism, if there is a specific. Thinks that we are afraid to give it in doses large enough. Pain will disappear in forty-eight hours, and profuse sweating will be produced with decrease of urates in the urine. Must continue the acid for three or four days after symptoms have subsided. Prefers the salicylic acid to the alkaline treatment.

Dr. Welch did not know anything about the acid, and but little about rheumatism. Attended a young lady with acute rheumatism with ankle joint badly swollen. Gave Dover's powder, and had ankles wrapped up in towels wet with cold water; next morning patient was able to be about. Attended another case, a woman; gave nitrate of potash and opium, and found it to be an excellent remedy in grain doses; thought he had a specific, but found by experience that he had not. Believes that no such thing as a specific for rheumatism has ever been discovered. It frequently occurs in healthy people without a depraved condition of the blood. Causes as various as causes of other diseases.

Dr. Goldrick thought there were many remedies, but no available ones. Nothing but constitutional treatment is of any use.

Dr. Hedges believes it well settled that the blood in rheumatism is always acid. Thinks salicylic acid superior to other remedies. Does not advocate large doses of the acid. Uses nothing else with it except sustaining remedies. Says alkaline treatment will always stand.

Dr. Constant thinks one remedy has really as much reputation as another. Main question is, to decide *when* to use the remedy. Uses salicylate of soda most, because the acid disagrees with the stomach. Uses salicylic acid in plethoric patients, and salicylate of soda in anemic ones, with excellent results.

Dr. S. C. Dumm said the causes were so different that we cannot lay down any special form of treatment. Tinct. ferri chloridi is often as good a remedy as can be found in chronic rheumatism. Aconite a good remedy in some cases. Related a case where he had left aconite, and by mistake about ten times the amount ordered had been given; was sent for, and found the patient suffering from all the symptoms of aconite poisoning; administered the proper restoratives, and patient recovered, cured of the rheumatism. Thought he had found a specific, but discovered his mistake upon further trial of the aconite. Says that the physician ought to see to it that the patient is bathed frequently.

Dr. White said he was a regular quack on rheumatism. When he treats a

case and cures it he never knows how to treat the next. Cannot tell what to do until he sees the case, and has used all kinds of treatment. Once left veratrum viride, and the patient was over-dosed; cured the rheumatism. Thought he had a specific, but was afterward undeceived.

Dr. McIntire never met with any benefit from salicylic acid. Has used all the general remedies, and finds none of them to be a specific.

Dr. Ropp has had no good results from salicylic acid. Once treated a lady for inflammatory rheumatism with aconite and gelsemium. She was overdosed and symptoms of poisoning produced, but the rheumatism was cured; then he treated a man with the same remedy, using large doses until tingling in the fingers resulted; rheumatism not cured, and his visions of a specific vanished.

Subject for discussion at next meeting, Diphtheria. Essayists: Drs. Hughs, Fay, and Hedges.

Retiring President Dr. F. W. Morrison delivered a valedictory address, full of witticism and humor, which was well received by the members of the Association.

Votes of thanks were tendered Dr. Morrison and the secretary, Dr. Clute, for the able manner in which they had discharged their official duties, and for their gentlemanly bearing towards the members.

The following resolution was then unanimously passed:

Resolved, That no member of this Association shall take by contract the city and township pauper business at any price whatever by the year, under penalty of forfeiting his membership in this Association.

Adjourned, to meet again upon the second Tuesday in February.

W. T. CLUTE, M. D., Secretary.

BUCYRUS, OHIO, JANUARY 16, 1882.

The physicians of Bucyrus, Ohio, met at the office of Dr. Geo. Keller Monday, January 16, 1882, at 2 o'clock P. M., for the purpose of expressing their feelings in regard to the death of the late Dr. Francis Von Meyer. On motion, Dr. C. Fulton was called to the Chair, and Dr. Keller elected Secretary. The Chair selected as Committee on Resolutions, Drs. M. C. Cuykendall, Geo. Keller and Georgia Merriman. Committee offered the following report, which was adopted:

WHEREAS, An all wise Providence has removed from our midst our former friend and fellow Dr. Francis Von Meyer.

Resolved, That in his death not only our profession but society has suffered a great loss.

Resolved, That we have always found him a genial, warm hearted friend, ~~possessed~~ of that modesty ever indicative of true greatness.

Resolved, That we attend the funeral in a body and wear the accustomed badge of mourning.

Resolved, That the Secretary be requested to furnish the minutes of this meeting to the papers of the town, and to the OHIO MEDICAL JOURNAL, and that a copy be sent to the relatives of the deceased in Stuttgart, Germany.

Meeting then adjourned.

C. FULTON, M. D., Chairmen.

GEO. KELLER, M. D., Secretary:

CORRESPONDENCE.

EDITOR OF JOURNAL:—I am glad to read the proposed "Act" in your December number. In section IX, it should read, * * * "continue in the practice of medicine," Obstetrics, or Surgery, or any branch belonging thereto, "in this State, shall," etc. It will be necessary to use the word "Obstetrics" in order to cut off this abominable horde of midwives who do three-fourths of this work, and never cease to slander the regular profession.

I reported five obstetric women who held themselves for public service, charging from \$1 to \$3 per case, to the Prosecuting Attorney of this (Washington) county, and after carefully reading our existing State law, he laid the case before the bar of Washington county, at Marietta. They discussed it at some length, and not being able to decide in his own mind, after the discussion, he told me that under the present law it was "a question," as to their right so to practice and *charge* therefor, and he would not bring action against them,

One of the Bar, an ex-Prosecuting Attorney, said he could easily make a jury believe that the "practice of medicine" did *not* include obstetrics, and hence these women were not violating the law; and *this* was the view taken by the majority.

Again, why not fight it out, and issue certificates to none but graduates, as evidence of ten years practice can easily be procured by every scoundrel? The fine in Section X, is *rather small*.

Again, as to druggists and pharmacists; almost daily I see the pernicious work of friendly (?) advice, and furnishing of medicine by druggists. Tighten up the screw legally, or let the profession withdraw its patronage.

Again; in Section IX, fourteenth line, "To practice medicine *in* and

from the place designated," leaves it foggy, and a doctor would have no right to practice outside of the country in which he has registered his certificate; at least a foxy lawyer would thus render it.

I think a "life office" in any of the departments will render the thing *foul*, and deaden the interest of other medical men of equal, or superior ability.

I feel a deep interest in the passage of this "Act," and shall post our Representative in the matter.

Respectfully,

MANLY H. SPRAGUE, M. D.

Beverly, Washington County, Ohio.

EDITORIAL DEPARTMENT.

EDITORS.

J. F. BALDWIN, M. D., Columbus.
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 T. C. MINOR, M. D., Cincinnati.
 GEO. A. COLLAMORE, M. D., Toledo.
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SPONGE GRAFTING.

This seems to bid fair to be a valuable acquisition to surgery. The process consists in introducing into an ulcer, for example, a piece of sponge, which acts as a stimulus to the reparative process, and is then absorbed and eliminated. Dr. D. J. Hamilton, of Edinburgh Royal Infirmary, introduces the method, and, in the November number of the *Edinburgh Medical Journal*, reports his experiments, with the practical conclusions to which they led him.

In a paper prepared several years ago, Dr. Hamilton stated that the vessels of a granulating surface are not newly formed, but are merely the superficial capillaries which have become displaced, being thrown up into loops by the action of the heart, the restraining influence of the skin having been removed. While making these observations, he was impressed with the similarity of the vascularization, as seen on a granulating surface, and

that which occurs when a clot or fibrinous exudation is replaced by a vascular cicatricial tissue. He came to regard the clot or lymph as merely playing a mechanical part, in any situation where it became replaced by a cicatrix, and that vascularization was not due to a new formation of vessels, but rather to a pushing inwards of those already existing in the surrounding tissues.

This being the case, it seemed to him that if some dead porous animal substance could be substituted, it would, after a time, become vascularized and replaced by cicatricial tissue. An accident suggested to him that sponge was the material sought, it being porous, like the fibrinous network in a clot, and thus capable of absorption, while it was so pliable as to permit of its adaptation to surfaces and cavities.

Dr. Hamilton reports five experiments in which these conclusions are fully sustained. One of these will suffice: A woman had several ulcers on different parts of her body. One of these, five inches in diameter, and from half to three quarters of an inch deep, was on her leg. The edges were indurated, raised, and, in places, undermined, while a slough at the deepest part of the wound gave the whole a putrefactive odor. Aug. 3d, 1880, he filled this ulcer, which was granulating at the bottom, with pieces of very fine sponge, prepared by dissolving out the salts by means of dilute nitro-muriatic acid, and subsequently washing in liquor potassæ, and then steeping in a 1 to 20 solution of carbolic acid. The sponge in the central part rose a little higher than the edges. It was fitted to the wound very accurately, and was inserted beneath the undermined edges. A piece of protective was placed on the surface, covered with a pad of boracic lint, and an ordinary bandage applied; the patient being kept in bed with the limb at rest.

The wound was dressed daily, but the sponge was not disturbed. On January 5th, 1881, the patient was exhibited to the Medico-Chirurgical Society, when it was found that not a vestige of the sponge remained, but that the wound had changed to a superficial, typical, granulating surface, measuring about one and one-half inches across.

Dr. Hamilton's idea is that if sponge be placed over a granulating surface, its interstices will become filled with blood vessels and cicatricial tissue, just as in the case of a blood-clot, and that ultimately the sponge will disappear in the wound, leaving an organizing mass of new tissue in its stead. The porous spaces in the sponge appear to be admirably adapted for this, and afford support to the young vessels. Even if the wound continues in a putrescent condition, organization will still go on, while in the case of the blood clot, putrefaction tends to prevent it.

We shall await with interest further developments of this line of treatment at the hands of other surgeons.

NOTES AND COMMENTS.

PROGRESS.—Mrs. Dr. Agnes M. Johnson, of Zanesville, was recently elected, unanimously, assistant physician so the Athens Insane Asylum.

“KANSAS CITY is to have a new medical college. If we mistake not this is the *eighth* in the State of Missouri. This beats Ohio, or any other State.”—*Detroit Lancet*.

The *Lancet* fails to fully appreciate the amount of medical talent in Ohio. We have at least ten medical colleges in this State, and one or two more are apparently in the embryonic condition; while still another, which was fondly supposed to be dead—by its enemies, at least—is beginning to manifest a highly inconsistent, not, indeed, to say indecorous, degree of interest in the funeral exercises.

VALUE OF VENTILATING SEWERS.—The town of Padstow, in Cornwall, is said to furnish an excellent example of the value of thoroughly ventilating the sewers (*Med. Times and Gazette*). Acting on the recommendation of Dr. Blaxwell, the Local Government Board Inspector, the local authorities have, during the last eighteen months, put into practice the course advocated at the meeting of the Sanitary Institute recently held at Exeter, that of ventilating sewers so as to permit sewage-gas to escape into the atmosphere as soon as it is generated, and before it becomes dangerous to the public health. As a result, the town has during the last twelve months enjoyed complete immunity from zymotic diseases.—*Louisvills Medical News*.

TO BLEACH BONES FOR OSTEOLOGICAL STUDY.—Bones may be bleached in several ways, though, in the main, the methods do not differ very much from each other. In the first place it is necessary to get rid of all extraneous matter, such as attachments of ligaments, muscles, etc. Next they may be laid for several months in cold water, after which they may be boiled with weak lye. Instead of macerating them in cold water, they may be treated with lye at once, but it is not so easy to get rid of the fatty matter in this manner. Some others do not use potash at all; but, after having boiled the bones in water, they dry them, and then place them in naphtha for several weeks. After the fat has been extracted, they are generally white enough

for all ordinary purposes. Still, they may be rendered whiter by immersing them for about twelve hours in a moderately dilute solution of chloride of lime (1 part of chloride of lime mixed with fifty parts of water, and strained). Finally the bones must be washed with water until the latter has completely exhausted every trace of chemicals or solvents employed on them. All bones do not stand treatment with potash equally well; the more slender, frail, and flexible a bone, the less potash it will bear. In fact, tender bones should be bleached without this agent.—*New Remedies*.

PRESCRIPTION REPETITION.—President Kennedy, of the Pennsylvania Pharmaceutical Association (*Druggist*, November, 1881), cites this instance of the dangers attending renewal of prescriptions: "A few years ago, a prescription was dispensed containing Lugol's solution and laudanum, for swelling of the knee joint, with particular instruction, how to use it. It proved to be a capital remedy to reduce swellings, for in a short time the patient recovered. Sometime afterward he was stung by a bee over the eye, which resulted in an extraordinary and persistent swelling. Remembering that he had used on a former occasion a good remedy to reduce swelling of the knee, he sent to the apothecary and had the prescription renewed, used it freely upon the eye, and now suffers from an incurable opacity of the cornea."—*Chicago Medical Review*.

PIROGOFF.—Prof. Nikolaus Pirogoff is dead. He was Professor of Surgery to the Medico-Chirurgical Academy at St. Petersburg, also Consulting Surgeon to various hospitals in that city. His name is best known to us through his method of amputating the foot.

"The profession of medicine has always offered, and probably will always offer, peculiar attractions to those who with weak principles and still weaker conscience desire to make profit by trading upon the credulity of their patients."—*J. G. Hutchinson, Detroit Lancet*.

ACTION OF JABORANDI ON THE HAIR.—Dr. D. W. Prentiss (*Philadelphia Medical Times*) reports a case of pyelo-nephritis treated by pilocarpin, in which the hair changed in color from light blonde to jet black during the treatment. The patient was, however, neurotic.

Salzer has been counting the fibres of the optic nerve. He counts four hundred and thirty-eight thousand. The number of cones in the retina he found to be three millions five hundred thousand.

A HALF HOUR WITH OUR ADVERTISERS.

The Cincinnati Sanitarium furnishes, as we know from personal observation, a pleasant home for the higher classes of insane, who are only made worse by the prison-like methods and manners incident to large public asylums.

John Wyett and Brother are well known as the manufacturers of *compressed pills*, as well as of a line of elegant elixirs. Their "Beef, Wine, and Iron" has been largely prescribed. Lately they have commenced the manufacture of compressed tablets for use with the hypodermic syringe. These tablets contain accurate amounts of the active principle to be used: as, morphia, atropia, strychnia, etc., either alone or in combination. With these tablets the physician makes a fresh solution at the bedside, and has the satisfaction of knowing precisely how much he is administering. We use them constantly, and can recommend them.

Maltine, in common with all the other meal preparations, has come into very general use within the last few years, as a tonic and nutritive in nearly all debilitated states of the constitution. One of the latest combinations is that with crude petroleum, being especially indicated in wasting diseases in which the lungs are involved.

Stauffer's Gynecological Instruments we have used, as occasion required, with much satisfaction. The privilege of exchange which is allowed, enables one to fit a troublesome case without needless expense.

Horseford's Acid Phosphates are especially recommended in cases of nervous prostration, sleeplessness, and dyspepsia. We are in receipt of a number of letters from Ohio physicians attesting the value of this remedy in these conditions. One of these, from Dr. A. B. Hovey, of Tiffin, gives the experience of the doctor himself in its use, for sleeplessness and dyspepsia. We have used it personally and in practice for a number of years, and our experience confirms the statements of our correspondents.

PUBLISHERS' NOTICE.

Attention is respectfully called to the bills sent out in the last number of the JOURNAL. The amounts asked for in each case are small, but the aggregate is large, and, as we are obliged to settle up the business of the former publishing firm, we greatly need the money. *Please remit at once*, before the matter again passes from your mind. It is not our purpose to force payments until compelled by neglect, and we believe it is only necessary to impress the importance of this matter upon our subscribers.

It occasionally happens that our mailing clerk by mistake sends bills to persons not in arrears: such mistakes are unavoidable among so many accounts, but they are far more annoying to us than to the recipients.

Very Respectfully,

26 North High St.

HANN & ADAIR.

COLUMBUS MEDICAL JOURNAL.

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No. 9.

COMMUNICATIONS.

ETIOLOGY OF FEVERS.

BY DR. S. A. CONKLIN, CANTON, O.

Read before Stark County Medical Society, Jan. 2, 1883.

The essential cause of fever is the presence of poison in the blood, by the dissolution of which the appearance of the poison is set up. The source from which this poison is derived, in my opinion, is the exciting cause of the fever, upon the same principle that inoculation is the exciting cause of variola, etc. But when we consider that many persons who are exposed to the influence of these exciting causes, entirely escape the disease, while others very lightly exposed are attacked, we naturally ask ourselves the question, why this difference in degree of susceptibility? and we recognize what we term predisposition—at times an individual or family peculiarity, although generally acquired. Sometimes these predisposing causes are so intense as to generate fever poison without the aid of exciting or foreign cause, but in the great majority of cases both the predisposing and exciting cause will be found to co-operate. I will first consider the nature of predisposition, or the action of predisposing causes; then briefly the exciting causes.

The poison is introduced into the blood, upon which its primary action is produced and in which it finds its nidus, or nest, and the substance capable of being converted into it and from which it is reproduced. We also further know that it is carried in this substance to the surfaces destined by nature to separate these different materials from the blood, sets

up certain specific actions, or irritation, and produces deposits which are regarded as efforts at elimination of the fever poison. Or, in other words, each form of fever has a special attraction for some specific material in the blood; for instance, scarlatina for the tonsils, typhoid for the intestinal follicles, etc., which are examples of the attraction of their excreting surfaces. This view is supported by two considerations; first, susceptibility to each morbid poison is, as a rule, exhausted by the action of the poison, while the susceptibility to other poisons remains the same. Second, fever, in common with other poisons, has a special attraction for whatever organ may be undergoing a change at the time of seizure. I have attended a few cases of typhus and many cases of typhoid fever, but I have never attended the same patient with two attacks of typhus, nor have I ever had complete evidence of a typhus patient having suffered a previous attack of the disease.

Not less remarkable is the second fact, that the susceptibility is exhausted only in the case of the poison whose attack has been suffered, the susceptibility to all other fevers remaining unaffected. This, I presume, does not admit of question. Scarlatina affords no protection from typhus, or variola, or measles; nor does an attack of typhus protect from any other form of fever. What the nature of this essential predisposition is, has never been discovered; but it seems to be a retrograde, metamorphosed-tissue condition. We might say fatigue, mental emotion, renal disease, are acting factors. We hardly know how to study the predisposing causes and their influence upon the blood and nervous system.

The aptitude to these fevers varies considerably in different individuals: in the young especially, if they have met with any disturbed condition of the nervous system or of any special organ, although when we say the young are thus susceptible to the action of the poison, we do not imply that they are more predisposed than other classes.

Predisposition to fever supposes something which interferes with the elimination of the poison before it has set up its specific action. It also supposes a condition of the blood to become subject to its action. To illustrate, we will suppose a young man has been exposed to the emanations of a fever patient and straightway gets intoxicated and exposes himself to cold, and by so doing retards elimination both from the lungs and kidneys, by checking the excretion of carbonic acid and urea: we know that, under this combined action of intoxication and exposure, the blood suffers decomposition.

Another example: a female at the menstrual period is known to be ex-

posed to zymotic disease, and the menstruation is checked by a severe cold, or mental shock, at the time of the exposure; she of course becomes predisposed in a high degree, and still higher about the puerperal period. The arrested menstruation retains the secretions and acts as the predisponent.

The power of ochlesis (that is, poison generated in emanations arising from crowded collections of persons) to cause fever without really the predisposing cause being previously present, should not be doubted. There is a similar power to cause other forms of fever in the emanations from obstructed sewers, cesspools, etc. Although we must confess that as both act by producing in the blood an accumulation of matter decomposing at the time of its reception, we must consider them predisposing agencies; they are not only that in fevers, but in all zymotic diseases, especially in scarlatina and cholera. We know of many epidemic visitations in towns, or streets, or even dwellings, where existed defective sewerage, or some impurity of water acting as a predisposing agency. We see the same precisely in epidemics of scarlatina which spread with extraordinary rapidity and fatality in overcrowded dormitories of schools. We often find patients suffering with a capricious appetite and occasional diarrhea for some days, and even weeks, prior to discovering symptoms of fever. I remember having attended a patient who had gastric derangement, headache and languor at least two weeks preceding the attack of fever; the fever itself running a course of four weeks. Fatigue is a very great predisposing cause, by increasing disintegration of tissue, and consequently producing a collection of products in the blood which often continues marked throughout the progress of the disease. Patients in whom muscular fatigue has been a predisponent and who have secondary blood contamination following, will ordinarily die.

The influence of prolonged exposure to cold and wet in producing a lesser degree of intensity in fevers, is not doubted. Any exposure which has a tendency to retard the elimination of effete material from the blood, such as wading, or working for a length of time in water, will act as a predisposing cause. I recall the case of a healthy young man who came under my care in 1869. I found upon inquiry that he had been for some time working at the river side in washing and sifting sand; after finishing his daily work he concluded to send his clothing across the river by his fellow workman and swim over; having eaten no food for some hours, and being hard at work, his system was necessarily reduced in vitality. I was called very early the following morning, and found him suffering

from a very severe chill and great pain in his loins. Fever followed, marked by oppressed breathing and extremely rapid pulse. In two or three days the skin was covered with petechiae. He had uncontrollable epistaxis and hemorrhage from the gums and bowels, and almost complete paralysis of his lower extremities, producing entire retention of urine, and necessitating catheterizing twice daily. He died on the morning of the eighth day. This is sufficient, I think, to prove to you that causes which increase the amount of the products of retrograde metamorphosed tissue in the blood from time to time, act as predisposing causes of fever, and I might say, of its special complications. Causes which act as predisponents through the nervous system, are mainly the depressing emotions of fear, grief, or anxiety, and the influence of prolonged cold. The connection between the predisponents and the occurrence of fever in the persons subjected to them, has sometimes induced persons to assign to them the power of generating fever; consequently ignoring its essential cause—a fever poison.

Another point I want to speak of in this connection is, that the influence of predisposing causes does not terminate with the invasion of fever, but continues during its course, often deciding the nature and seat of its complications and termination. If the predisposing cause be mental, nervous symptoms decidedly will appear in the course of the fever. If it be the arrest of menstruation, hysterical symptoms will most generally present themselves as complications.

Besides the common forms of predisposition, we frequently meet with influences which seem to act by impression, as it were. Such are the cases of individual predisposition, or sometimes family forms of predisposition. One year ago the past summer I attended a young man who was suffering from typhoid fever. The nervous symptoms were unusually severe throughout the whole course of fever. Suddenly one morning I discovered he could not swallow any kind of food—complete dysphagia—fluids came, being ejected with great force.

To recapitulate. We find: (1.) In order to produce fever, it is necessary, not only that the fever poison should be received into the blood, but that it should meet with a material capable of converting it into a substance identical with itself. (2.) That in a number of persons this material does not exist in the blood, and that consequently they are not susceptible under any amount of exposure. (3.) That this susceptibility, though exhausted with reference to this particular poison, remains undiminished as to others. (4.) That the susceptibility is capable of being

increased in various degrees. (6.) That the material in the blood on which it depends is probably different in every form of fever. (6.) That the predisposing causes are of two kinds: First, those which act immediately by increasing the amount of products of disintegration of tissue in the blood: as fatigue, cold, and moisture; second, those which by their depressing influence on the nervous centers produce indirectly the same effect by lessening the vital resistance to change. (7.) That the nature and amount of predisposition have a very great influence not only on the formation of fever, but also upon its course, complications, and results.

I will now briefly consider the exciting causes, or the sources from which the poison is derived. These I consider have a bearing upon preventive measures, as well as classification of fevers. If it could be proved that there is but one source of fever, we would have no species of fever. But we know the disease may arise from many causes, and all very different. If we institute inquiry as to the sources of fever, we will find certain localities seldom free from some form of fever, while others are seldom affected. My observation has taught me that the condition under which many fevers exist, is the co-existence of close, poorly ventilated houses crowded with persons; want of cleanliness and clothing; often scarcity of food and fuel, and at other times depression of strength and spirits from want of employment.

Again, in very similar localities and where the situation is very much the same, but in which sources of malaria exist in the forms of defective sewerage, open cesspools, half-dry sides of rivers, or such like foci of what is generally termed "civic miasm," fever very often breaks out in the course of a dry summer as an epidemic disease, but confined to the same locality, being capable of spreading to a very limited extent, if at all, and manifesting in a very feeble degree contagious properties. Writers speak of another class of fevers, which will appear and spread with great rapidity among the poor in crowded localities. This class does not wait for transportation by persons, but is rapidly diffused by atmospheric influence, breaking out in places remote from each other.

It needs no argument to convince any observing medical brother, that fevers have essentially different natures and modes of operation. In the first form we find that the influential conditions appear to be the generation and retention of the poison arising from living beings. The causes which favor the generation of the poison are cold, want of food, fuel and ventilation; and, in other instances, depression of the mind and body. To illustrate the above, I will give you my experience in the latter part of

the winter of 1869. It appeared singular to me at that time that fever should appear after three months of extremely cold weather. It was a poor colored family numbering seventeen; father, mother, thirteen children, and two grand-children. The building was a log hut composed of one room, eighteen by twenty-two feet. The support of the family depended on the husband and the two older sons, who could scarcely earn enough to purchase food sufficient for their subsistence, without providing fuel and clothing against the inclemencies of the winter. Consequently they lived with their little hut closely confined, and the pure air in every possible way excluded. The fever at first was not violent, the symptoms indicating to me an attack of distemper which I called "log house fever." The oldest son was first prostrated; soon after the father was stricken; and in twelve days nine were attacked one after the other. The fever seemed to be slow in its approach, but there was great loss of strength and vitality. The pulse, which was quick and full, tremor of hands and arms, and the brown spots on the skin, to which may be added its infectious nature, left no doubt in my mind of its being the same as what we now call jail or hospital fever, cold being the cause of improper ventilation which thus gave rise to the poison. Perhaps it would be interesting to you to know the results of the fever upon this poor colored family. Of seventeen in the family, thirteen had the fever. Of the thirteen, nine were lying under the sod within four weeks, only four being spared to tell the sad tale.

The second source of fever poison is most generally met with in large towns, but is by no means confined entirely to them. Some of the most remarkable outbreaks of epidemic fever have occurred in country districts, and sometimes in isolated houses. However, the essential condition has been the same in all instances under my observation, and which I have read of, viz.,—either gases arising from fecal matter decomposing in a sewer, a cesspool, or on banks of half-dry streams, or from drinking water contaminated with sewage. This class of fevers seems to affect the rich and poor alike. It does not usually commence in the winter, but rather in the summer and autumn, subsiding on the coming of rain and winter.

The character of the fever produced by fecal miasm is, that the poison seems to affect the blood-making organs: Peyer's-glands, the mesenteric glands, etc., being its elective seat. When received into the blood in great amount, it acts with intense virulence, producing rapid death, and acting on the brain very much like a narcotic poison. Dr. Liebermeister

gives examples where persons have died in twenty-six hours, who were engaged in opening drains. Murchison gives cases where they have died within forty hours, the cause originating from cesspools.

It must be admitted that we meet with cases from time to time, though not frequently, in which the appearance of both forms of disease is present in the patient. Some authors contend that both forms of disease arise from the same poison, derived from the same source—contagion, and are varieties of one species. Others assume that in the locality two sources of fever poison are present, namely, ochlesis and fecal miasm.

We have another, or third, exciting cause of fever: viz., atmospheric or epidemic influence. We have often noticed simultaneous outbreaks of fever in remote places; the fever being generally of uniform character in all cases. At times, complications of a peculiar kind appear, such as a yellow tinge of skin, indicating congestion of liver, stomach and spleen.

To sum up briefly the observations of the etiology of fever, we conclude that two conditions must exist for its productions.

(1.) A morbid poison derived from animal miasm, fecal miasm, or epidemic influence.

(2.) The presence in the blood of some variable matter in a state of retrograde metamorphosis—the true nidus of the fever poison upon which its catalytic action is exerted, and in which it is increased and reproduced.

It, indeed, seems that the predisponent is necessary, for we often see persons exposed for a long period to the imbibition of the poison but who have the power in the system to eliminate it from day to day, until some action, such as cold or mental shock, arrests the excretions; then fever will follow.

Also it appears that some of the exciting causes, such as cold and shock, really act by suddenly promoting the predisposition, either by directly increasing the disintegrated material, or indirectly, by their depressing action on the nervous system.

In conclusion, we can safely assume that a person previously healthy, but susceptible of the influence of fever, will receive the infection of typhus, if exposed to the emanations of typhus; and if exposed to the emanations arising from fecal matter of cesspools and sewers, he will have generated a fever of an abdominal type, and that neither confers any immunity against the other.

DYSENTERY.

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Dysentery is known among the laity as "flux," or "bloody flux; technically, colztis or colonitis, though generally called by physicians dysentery.

On account of its frequency, painfulness and fatality, it is of special interest to every practitioner of medicine.

The causation is not very well-known. It occurs at all ages, and in both sexes. The more common causes are exposure to cold and dampness, malaria, bad air, unwholesome or badly cooked food, impure water, and bad hygienic surroundings. It is most common in warm climates. It is more severe in armies, jails, or prisons, where large numbers of persons are crowded together with unfavorable sanitary conditions. It is more prevalent in autumn and the latter summer months. One attack confers no immunity from others, but rather predisposes to them.

It is sometimes complicated with hepatic abscess, or enlargement, or inflammation of the liver. This is especially the case in warm climates. Whether dysentery and hepatic abscess have any mutual relation is still undecided, though it is very likely they are dependent on the same cause though mutually independent of each other.

Dysentery is essentially an inflammation of the mucous membrane of the colon, though it is considered a specific febrile disease by some authorities. I think that in some cases dysentery is a local affection, a colonitis; but I am inclined to the opinion that as a general thing it is a systemic disease. It is generally characterized by great nervous depression, out of proportion to the local lesion. It is generally accompanied by a considerable febrile disturbance, severe griping pains, tormina, and tenesmus, with frequent and very painful efforts at stool and bloody mucous discharges.

The mortality, in armies, prisons, jails, and where the hygienic surroundings are bad, is very high, but in civil life, with proper care and medical treatment the mortality is comparatively light.

As to treatment, first, evacuate the bowels with a saline purgative, my favorite being sulphate of magnesia, which serves the double purpose of clearing out the bowels of any offending fecal matter, and of relieving the congestion of the parts, while its after effect is astringent. After the

bowels have been evacuated, I give opium in some form, sufficient to check the bowels. Sometimes it takes enormous doses to do this. Opium is the remedy above all others to ease the pain and relieve the tenesmus and tormina. I have tried the ipecac treatment, but my experience with this drug has not been very satisfactory.

THE DIAGNOSIS OF INSANITY.

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Mania.

Insanity, exclusive of Idiocy and Imbecility, which properly do not belong to and are not included by many writers in a treatise upon insanity, may, in order to facilitate diagnosis, be divided into three general classes: 1st, Exaltation; 2nd, Depression; 3rd, Loss of mind. Each individual must be assumed to have a normal mental state. To a certain extent this must be ideal—hypothecated. It is impossible to know all that appears in consciousness with any individual—his ideas, thoughts, imaginations, determinations, desires, feelings, yet before insanity can be alleged this must be determined or approximated. The only standard by which he then can be judged is himself. If we define insanity to be a departure from the normal mode of thinking, feeling and acting, of an individual, due to disorder of the brain, then there is no other. If idiocy and imbecility are not ingredients of the case, and only acquired conditions, we must assume that if insanity exists there is a departure from a normal condition.

The three classes above given are based upon the phenomena observed, the chief characteristics or features of a case. Like one division of the mind into departments and faculties, it is arbitrary. It may be said the mind is not divisible and that these landmarks are imaginary, the same may be said to some extent of all sciences. The earth is not divided by the imaginary lines of latitude and longitude. The tropics are equally defined by imaginary lines; the divisions of time and space are only assumed for convenience; the parts of speech in grammar are made more or less in number according to the views of the writer. If mental science assumes the character of a science at all, it must be governed by

the same rules that govern all sciences. Science is knowledge reduced to a system, and mental science is no exception to the rule.*

When this normal state has been determined, that which is apparent above this, above par—is Mania. Exaggeration of the motor activity may be limited to the sensibilities, may express itself in action, or may involve intellectual action. That which falls below this line, characterized by want of motor power, apathy, laborious, slow and almost arrested action—a condition the opposite of mania, is melancholia, the abolition of mind is dementia.

In this lecture we shall consider Mania, but not Monomania, Homicidal Mania, Mania Transitoria, or other alleged forms. These will be made the subject of a special lecture.

We may divide our consideration of Mania into, 1st, Stage of Incubation; 2nd, Acute Mania; 3rd, Chronic Mania.

What we have said of Idiocy and Imbecility as an expression of an hereditary condition may be applied to all forms of insanity. They are often not the simple expression of the condition of an individual, but the aggregate of accumulating tendencies. The expression of race degeneracy is often clearly manifest in these multiform disorders. The insane temperament may never exceed eccentricity, irritability and strange conduct. It may show itself at birth, as in idiocy; in youth, as in imbecility; it may follow a bright early manhood. If no exciting cause develops the latent influences the individual may escape altogether. Often we hear it said a child was unusually bright until teething, cholera infantum, or one of the multitude of ills that afflict the young, destroyed its mind. As we remarked of imbeciles, so may we say of all these conditions. The more extensive and careful your observation the more firmly will you be convinced that man seems to be endowed with a certain amount of vitality to run a given course. Decay and failure may arrest this course at any period of life independent of acute disease. His force seems to be expended, and with or without an exciting cause he breaks down. This may be determined by an exciting cause, as domestic, financial, or other troubles.

When you are called to examine a case of alleged insanity, you will often be informed that trouble began at a certain time, and if you stop there may conclude that the invasion was sudden and unexpected. In the papers coming from the Probate Courts upon which the patients are admitted to the asylums, nothing is more common than to see inserted that it is of two, three, or a few days duration, or the same number of

* In our "Analysis of the Human Mind," which has been for some time in preparation, we trust this is made much clearer. See author's Monomania published by Ohio Medical Society, 1874.

weeks, when this period given only marks the duration of the fully developed disorder.

Mania is a disorder which has its origin, its primary seat, in the sensibilities. This department of the mind first shows evidence of disorder and in some instances years before intellectual disorder is manifest there is a radical change in the feelings, desires and tendencies of the individual. The individual who has been good natured, easy and quiet, becomes irritable, sensitive and intolerant of the opinions of others or of contradiction. Where this is more marked there may be at one time the most lavish affection, it may even be desired on the part of others, and he receives caresses with evident satisfaction. This is soon followed by indifference, abuse, hatred. What gives pleasure at one time may irritate at another. The moral faculties first show disorder. The most frequent early change of conduct is that towards family and friends. Patients themselves recognize it and if their confidence be gained will state that to them it is as strange as to their friends. One of the most violent cases of mania ever under my care begun in this way. My patient stated to me that without cause or motive he had changed radically in his feelings toward his wife, several years before he was recognized as insane. He said it gave him great pain to know that he felt a dislike where his affections had before been so strong. He said the change was with himself, and not any fault of his wife. He concealed it so that she did not suspect it for a long time. The intellect was not impaired. That which should excite suspicion is that the rapid changes of feeling which are often manifest are without motive—no cause can be assigned. A lady consulted me concerning her husband who was in the prodromic period of what proved to be violent mania. She said "I cannot understand it. One minute he is in the best of humor—is way up—laughs, talks a great deal, and dances around—the next minute he is way down—cries without cause, is sad, says little, is out of humor with everybody—nothing pleases him." At first many cases control their feelings and give expression to them only in their looks. They are vexed and worried by their condition, cannot endure society, and seek solitude. One man under my observation would leave the house at night and sleep in his barn. If questioned as to their conduct it often provokes anger and abuse. Some who recognize their condition, when their anger has abated, apologize, and regret what has occurred, yet they again and again repeat the offense. One old gentleman who gave no evidence of this irritability except before his friends, informed me that he had tried to control himself but could not,

that he was not his own master. It may seem strange that a man capable of reasoning upon his condition, and who could conduct himself well before strangers, would not be able to before others, but such seems to be the fact. The stranger affords a stimulus to the will that the presence of friends does not.

At this period often other symptoms are manifest which should excite serious attention. There may be derangement of the digestive organs, pains in the stomach, abdomen, any part of the body, headache, toothache, general bad feeling. There is often loss of sleep, troublesome dreams, vertigo; disturbance of circulation manifest in a variety of ways as violent pulsation of vessels, palpitation, redness or paleness of face; febrile states with constipation, although the appetite be increased, often voracious, with foul tongue. With some cases there is suppression of the menses, with some exaggeration of venereal desires. The features are altered. Often the muscles of the face twitch, there is slight trembling throughout the body. When the case is fully developed all bad feeling disappears. The patient then declares nothing is wrong. Want of self-control in action manifests itself much earlier than in the intellect. In many cases the actions are so disordered and irregular that it seems impossible that they are not directly the result of mental disturbance, yet the power of concentration of thought, of forcible, logical reasoning is such, the freedom from delirium so manifest, that it must be conceded that the lesion is one of the emotions rather than of the intellect. The feelings and actions are as irregular as the thoughts seem to be incoherent later in the case. This is especially true of hereditary taint, where irritability, violent temper, and want of self-control predominates. With some the senses give evidence of disorder. There may be ringing, or other sounds in the ears, sparks fly before the eyes, taste and smell impaired. The patient may or may not be thirsty. Respiration may be slow; the more the exaltation the more rapid is respiration.

Cases are very common which are preceded by melancholia, at times extending even to stupor. Patient feels depressed. Patients have said they feel as if under a cloud or weighed down. I think that in most cases where the prodromic period extends over any considerable period of time, there is early in the case a sense of depression, gloom, ill-feeling. As it assumes a more active form the patient becomes restless, feels impelled to move, walks continually, is sleepless yet talks coherently. Often they get up in the night and wander around, leave the house. One patient at this period would start out every morning at 3 or 4 o'clock and walk for miles

in the country. He would stop at houses he never had visited before—sometimes staying for breakfast. Everything red attracted his attention. He said he saw blood continually. At one place he took the hoops from a rain-water barrel because they were painted red, gathered pieces of bricks, broken rocks, and waded into a swamp after red weeds. One morning he brought home a small turtle because it was red beneath the shell. He was perfectly coherent, perfectly rational, and no one could detect any intellectual disorder further than was manifest in these actions. He slept little, was constipated, yet complained of nothing except his restless feelings and tendency to keep in action. As the trouble advanced he began to comment upon the conduct of his friends. He then began to give away money upon the street. In one evening he gave away nearly one hundred dollars in sums of five, ten and twenty dollars. He became very violent. After recovery he remembered every one to whom he had given money and the amount. I urged upon his friends the necessity of confinement for him, but from fear they would consent to no action until he became quite bad. As the melancholic state gives way to excitement a change of feeling as to person and personal identity takes place. As in melancholia, the whole mental powers seem to be concentrated upon a few ideas, and those chiefly self; so here we find this for a time manifest, but they are turned outward. The expansion is characterized by a feeling of vanity—the humility, timidity, irresolution gives way to a feeling of self satisfaction, boldness, determination. There is, however, instability, a want of order in affairs, want of neatness, and a disregard for the rights of others. As the case progresses and the feelings are still further altered there often springs up doubt as to personal identity; sleep becomes less and less, the agitation increases, thought and speech become involved and there is rapidity and incoherence of expression. Now, the passions begin to have more control. There is less self-control, the want of harmony between the intellect and sensibilities becomes less apparent. Delusions appear.

In the early stages the judgment often manifests disorder before other faculties seem to be involved. They engage in speculations that are ruinous. Business failure results. As the disease develops this is assigned as a cause of the insanity while it is but the effect. They have not gone back to the root of the evil. Want of prudence, caution and judgment were the causes of the disease and financial trouble resulted. At Dayton Asylum, of 1138 cases from all causes, admitted, 186 were alleged to be due to financial troubles.

The feeling of self confidence and personal power induces risks that earlier in life they would not have taken. It is at this period excesses of all kind are committed, as sexual indulgence, intoxication, long and expensive journeys, excessive expenditures, building of residences they have not means to justify, etc. The period of incubation may be brief—it may last for years. It may advance by so insensible degrees as to excite little suspicion, and friends only awake to the nature of the case when the final crash comes. Often long before this the patient is aware of it. He compares himself with his past and makes the only true comparison that can be made. He recognizes his variable moods, his motiveless acts, his change of feelings, and while he may not understand it, knows that all is not well with him.

We have said that there is a time in all cases, where the prodromic period is not brief, in which melancholia is manifest. Melancholia and mania are regarded by some as but different stages of the same disorder. The excitement follows the depression as fever follows a chill. There are infinite degrees of blending the two conditions in cases of insanity. Exaltation may predominate to-day, while depression may follow to-morrow. Some cases of a recurrent form pass through a period of melancholia, ripen into mania, which subsides into melancholia—a lucid interval follows, to be in turn followed by insanity. In the early stage, with some, it is impossible to determine what form the disorder will assume, whether melancholia or mania. Patients are sometimes admitted to asylums as cases of melancholia, which in a short time become violent cases of mania.

With mania there is exaggerated activity of physical and intellectual nature, expansion—the patient acts too much. The moral powers and will are in subjection. There is a want of moral power. Shame is scarcely felt by many after the most indecent exposure, outrageous language or conduct. In this respect it differs from melancholia. The melancholic exaggerates his faults—is absorbed with self—and cannot exclude from his thoughts the sense of his own unworthiness. Mania may assume the form of a religious furor, but the individual may never have been religious, and is as apt to swear when angry as to pray when quiet.

Mania fully developed, ushered in with an outbreak of violent form with intellectual derangement without any perceptible prodromic period, is more uncommon than other forms of insanity. When there is a sudden outburst, with little previous warning, the case is generally of the form

known as acute delirious mania, or typho-mania. In many of these cases the excitement is terrible. There is, however, a difference in the condition from that of ordinary mania. The patient succumbs to the excitement and typhoid symptoms soon appear, while in common mania often the activity, noise and general insane condition continues for years with little detriment to the general health of the patient. What is most surprising in many cases is that there is so little evidence of ill effects from the general disturbance.

Our second division is that of acute mania. As a rule the fully developed disease is but an exaggeration of the excitement that becomes manifest during the prodromic period. The patient who has been able to fight off his emotions loses self control. He is overpowered by them; the intellect is involved. Rapid thought, incoherency, shouting, singing, swearing, now, in extreme cases, are fully manifest. They are abusive, filthy in habits, sleep little, are in constant action; many tear off their clothing, break and destroy all within their reach. This period of excitement may continue only for a few days and the patient settle into a calmer state. He then may eat well, sleep well, or still continue to be sleepless. The condition is, however, much modified. Few patients continue in the state of extreme excitement that marks the period of explosion for any great length of time. They settle into a more passive state, with delusions, may continue to talk incessantly, be in continued action, yet are not violent unless angered.

They are not devoid of reason, for until demented they are influenced by rewards and punishments. Thus, a piece of tobacco will often cause good behavior, check violence and induce a great change. Many of them yield to the same moral influences that govern children, are equally as sensitive to kind treatment. As a class they are very vexatious to deal with, constantly giving trouble and making complaints.

Patients are seldom at this stage of the disease wholly devoid of mental power, and many still retain some mental faculties not disordered. Memory with many is good. In cases where there is great excitement, and impressions made are transient, there is so little attention given that nothing remains in memory.

Delusions of the senses, and of hearing more frequently than of visions are common. The patient often converses with imaginary voices.

When the patient has passed into the settled condition we have given and it assumes a continuous form it is said to be a case of chronic insanity. The term, however, is used in a variety of ways. It often is

used to indicate an incurable case. Again, cases of more than one year's duration are called chronic.

In law a man is supposed to be sane until proved to be insane. When once adjudged insane the presumption continues until he is proved to be sane, yet that this presumption may continue it must be shown that it was of a chronic or continuous form. Where crime has been committed by a party who had been adjudged insane, it sometimes is alleged as a defense that the insanity continued. If the evidence shows that an individual at one period was insane of a chronic or continuous form, whether adjudged so or not, the presumption will continue, but all these presumptions may be rebutted. If there be lucid intervals the burden of proof will rest upon the defense to show that the act was not done during the lucid interval. After, all these presumptions amount to very little, except that *apparently* they change the burden of proof, while one who has been often in court is convinced that practically they change nothing. The jury brings in its verdict with very little regard to them.

INEBRIETY AND SOME OF ITS PROBLEMS.

BY T. D. CROTHERS, M. D., HARTFORD, CONN.

[Superintendent Walnut Lodge.]

The time has come for a study of inebriety from a medical standpoint. Its relations to health and sanitary science are more apparent every day. Insanity, idiocy, pauperism, criminality and disease generally, are traced back to inebriety as the most potent cause. Society is alarmed. Moralists and reformers occupy this field and explain everything, and point out the remedy. All mystery and obscurity are promptly solved by teachings of inspiration. As insanity and witchcraft were the work of the devil, so inebriety is the expression of a heart deceitful and desperately wicked. The greater the mystery the clearer the explanation of vice and sin. There is everywhere a spirit of agitation, a restless casting about for some means to check and prevent inebriety. In this, public sentiment is a quarter of a century ahead of the medical profession. The great personal question, coming from homes in all parts of the land, "What shall we do with the inebriate?" is now answered by clergymen and reformers. The medical profession consent by silence to the growth and development of theories

based on the superstition of the dark ages. To call inebriety a vice, simply because its early stages are unknown, and attempt to prevent it on this basis, is to practically ignore all teachings of philosophy and science.

Inebriety, like insanity, has a well-marked "border-land stage," in which health and disease, sanity and insanity, meet and blend. In some cases it may last a long life time, and the patient be alternately temperate and intemperate. In others it is of short duration, the penumbra rapidly merging into the umbra. The great outer circle, where the shadows of disease first appear, is soon followed by the positive darkness of organized lesion. •

Alternations, halts and periods of apparent health, are seized as arguments to prove the absence of disease and the presence of a vice-impulse which might be controlled by the will.

The periods of perfect sanity in the insane; the seasons in which the hysteric and epileptic seem in good health; the moments of apparent health in consumption, rheumatism, and many other well defined diseases, will furnish the same arguments and the same conclusions.

The inebriate who drinks to great excess to-day, under circumstances of apparently slight temptation, and in opposition to many contrary influences, and to-morrow abstains in conditions of great temptation and adverse surroundings, is no more an anomaly or contradiction than the man who is perfectly sane on all questions but one. This strange confusion of strength and weakness, of mental symptoms that illustrate the best and worst elements of human nature, clears up when seen from the standpoint of science. The student who studies the clinical histories is amazed at the regular order and uniform progress from cause to effect. Every case begins in some change, inherited or acquired, in both the function and structure of the organism. Its march is progressive, and clearly in obedience to physical laws and forces practically unknown.

Of the two stages of its progress, the first is almost unknown, and terminates in the first excessive use of alcohol. It may be called the neurotic stage, and to the expert will be found full of hints and intimations of inebriety far in advance. In this stage are all those cases of nerve exhaustion, and instability of nerve force, nutrient perversions and disturbances. In many instances delusions about foods and drinks are the physical symptoms. In such cases heredity is prominent, and these delusions are but the unconscious expressions of a defective organism, seeking to build up against a future inebriate degeneration. In much the

same way the almost fanatical efforts of persons, who have never drank themselves, to reform inebriates, are strong hints of the same organic tendency. Such efforts in reformed inebriates are both physical and psychical expressions of the same condition.

Marks of inheritance so complex and numerous that a volume would be required to describe them, tell of the variations and convergence of morbid conditions, pointing to the certain outburst of inebriety in the future. Surroundings, certain conditions of living and occupations, acting on special nerve organizations, will be followed by inebriety, as surely as smallpox springs from its germ. Given, the brain conditions and surroundings, and inebriety can be predicted with certainty. In all these cases there are signs of physical and mental defects, and innumerable minor hints and symptoms, that, like signal flags, are unmistakable, and all of which must be studied as carefully and exactly as the pathologist studies his specimens. Half truths are more dangerous here than profound ignorance,

The next stage begins at the first toxic action of alcohol and goes on to death. This is better known, and is supposed to embrace the entire subject, based on the supposition that alcohol is always and ever the cause: a great blunder growing out of superstition and ignorance of the subject.

From this point the march of the disease is often broken by long obscure halts, precipitous strides; sometimes following a definite line, then changing to other forms. The physical effects of alcohol not only bring out degeneration of the nerve centers, but change the type and form of this disorder. Sometimes distinct pathological changes begin at once from this time. In other cases emotional changes of character, temper, habits and disposition follow. The brain may show signs of failure, and delusions and hallucinations appear. Often a species of "reasoning mania" is present, in which from false premises the most elaborate line of conduct is worked out and defended with astuteness. As, for instance, one will explain the reasons for the use of spirits; another will persist in using alcohol to intoxication, and another will continue experimenting, trying to use it moderately, although he fails every time.

In some cases the reasoning faculties are apparently unimpaired, and clearly comprehend their danger.

Often they will seize upon some theory of cure, and exhibit great earnestness and activity to recover. But they sooner or later fail, and fall into more abject hopelessness than before.

As the case progresses, two conditions seem to alternate one with the other. One of abject and hopeless despair; the other of extravagant and boundless hope. In the one case, spirits are used with every temptation, and no effort is made to aid others in helping himself. The man is a practical fatalist, and is said to have no will power. In the other case, he is a most enthusiastic temperance man, joining every movement that seeks to help the inebriate. He is extravagant and delusive in his words and deeds. The delusion of strength, to stop the use of spirits at will, in many cases remains to the last moment of existence. No reason, experience, or advice can ever break up this impression. Like the laws of the Medes, it is unchanging.

The use of alcohol follows two quite distinct conditions, which appear from a careful study of cases: One a distinct morbid impulse, that grows into a literal mania, a psychical condition of the mind in which alcohol is demanded with the same urgency that water is craved by the body after being deprived of it for a long time; truly a thirst mania, which becomes the central thought and impulse of the organism. The second condition is that of depression, lowered vitality, and is a form of psychical pain; which seeks relief from any source, at all hazards. Some profound change of the functional activities of the nerve centers (and no doubt a real organic alteration) is manifest in symptoms less pronounced than pain, and yet more general and agonizing.

Alcohol is a pleasing sedative, and its effects are craved as positively as food is demanded for the famished body. Opium and other drugs are used in the same way. This latter condition is very often produced by mental shock or psychical traumatism. Strain, both of the muscles and nervous system, is also an active cause. The former is most often inherited, and only another form of insanity, idiocy, or profound nerve defect in the parents.

A vast complexity of symptoms, both physical and psychical, follow all these cases. The symptoms are very obscure in a general study, but when carefully recorded and grouped will be found to follow a regular order of march, as much so as typhoid fever or consumption. No chance or accident enters into the history, but the foot-prints of laws are every where seen that are exact as those which govern the planets.

The clinical histories of cases of inebriety, beginning at some point more or less obscure, follow along a path, the outlines of which indicate unmistakably the presence of physical laws, or physical disease. Inebriety is

ever and always a physical disease, and this can be proven by every physician in the land.

It is a matter of fact which no theory can change. When and where it begins, and what are the conditions which govern its origin, development, growth and decline, will require long years of study and observation to determine. Practically, if it is true that inebriety follows certain laws of development, as do other diseases, their discovery opens a wide field of prevention.

What is wanted to-day, is, a thorough investigation of this subject from the standpoint of science. Such a study must ignore all theories and seek the truth from carefully observed facts. No field of science demands exploration more imperatively than this. Insanity, criminality, and other great evils, sink into insignificance compared with it, for inebriety is more widely extended, and touches the hearts and homes of all ranks and conditions of life.

I have no new theory or plan of treatment to urge, but simply protest in the name of science against the dogma of vice and the spiritual methods of cure. Inebriety is a medical and scientific subject, and must be lifted out of the "squatter sovereignty" of moralists and non-experts, and organized into a state of law and order, where the truths of nature shall be recognized, and the methods of prevention and cure can be applied along these lines.

OBSTETRICS.

MANGANESE IN AMENORRHEA.—Drs. Sydney Ringer and Murrell write to the following effect: "For some time past we have used permanganate of potash with much success in the treatment of certain forms of amenorrhea, and are satisfied of its value. Our observations have extended over a period of thirteen months, and we have now notes of sixty-nine cases. The majority occurred in hospital practice, but some were private patients. A small number remained under observation for a few weeks only, but the majority continued to attend for a much longer period; so that in some instances we have a complete record of the menstrual history for a year or more. In some cases the amenorrhea was the cause of the patient seeking advice; in others its existence was mentioned incidentally, the patient suffering from some other complaint. Our cases are such as come under the care of the general as distinguished from the obstetric physician, and do not include those requiring operative interference. As a rule we refrained from making a vaginal examination, but with this exception our notes are complete. We have used the permanganate in two forms, first the pharmacopeial solution, and secondly the permanganate made into pills, each containing either one or two grains. Generally we begin with a grain three times, and then gradually increase the dose to two grains four times, a day. Our most striking results have been obtained with the larger doses; a large dose sometimes succeeding admirably after the failure of a small one. Before commencing treatment we inquire carefully into the menstrual history of the patient, and as a rule give the remedy only for the three or four days immediately preceding the expected period, but should it fail to produce the desired effect we direct the patient to continue steadily taking it, and in some cases it has been taken continuously for nearly three months. In our experimental observations we have given the one drug only and have done nothing in the way of accessory treatment. Our most striking results have been obtained in young women between the ages of eighteen and twenty-five, who from some accidental or trivial cause, such as catching cold or getting wet, have 'missed' once or twice after having been regular. The administration of one or two grains of permanganate of potash in pill three or four times a day for a few days before the time of the expected period will bring on the flow almost to a certainty. In some instances the periods were brought on after the patient had ceased menstruating for over a year. In the case

of country girls who have 'seen nothing' for a month or two after coming to town the treatment has answered admirably. Often enough patients do not consult their doctor until they are 'overdue,' until the time of the expected period has passed by for some days. Even then the prompt administration of the permanganate will often bring on the flow at once, but should it fail to do so the treatment ought to be continued, and the patient will probably menstruate normally at the next monthly time. Generally our efforts are not crowned with success until the medicine has been taken for at least three or four days, but in some instances the permanganate acted with striking rapidity, the menstrual flow making its appearance after only two or three doses had been taken. It is not necessary to discontinue the treatment on the appearance of the menses; in fact we generally tell the patient to continue taking the pills three or four days longer, finding that it facilitates the flow. The permanganate often succeeds well after the failure of other remedies, such as iron, aloes, nux vomica, strychnia, pulsatilla, nitro-glycerine, and hot mustard baths. Sometimes, however, it is necessary to give it for six weeks or even longer before the desired result is obtained. In those cases where the patient has menstruated only once or twice, and has then entirely ceased for some months, our treatment answers well; the menstrual function is re-established, and thenceforth proceeds normally at every successive monthly period. In some cases there was no actual amenorrhea, but the flow was scanty, lasting perhaps only a single day, or it may be only a few hours. Here the administration of the permanganate prolonged the flow, and even in some instances when it had ceased brought it on again. In girls of about fifteen or sixteen, who have never menstruated at all, the permanganate, as might be expected, is not so certain in its action; but even here it not infrequently acts promptly, bringing on the flow at once. In some cases where the general health was bad, and the permanganate had failed, we suspended treatment for a time, and sent the patients into the country for a month. On their return we gave the permanganate a second trial, and it succeeded at once. We have, however, sometimes failed to bring on the menstrual flow even when the patient was in fairly good health, and when there were the usual indications of puberty. It is not only in the case of young women that manganese is so useful, it succeeds almost equally well with women between thirty-five and forty, who, as the result of many pregnancies and much suckling, have ceased to be regular. Here, for example, is a typical case: A married woman came to us complaining that she was never regular. She had had nine children in as many years,

and rarely 'saw anything' more than once between her pregnancies. She had been suckling for eight months, and had not been 'poorly' for seventeen months—the nine months she had carried and the eight months she had suckled. She was not in the family-way, but said she expected she would be soon if she weaned the baby. She did not know when she ought to be 'poorly,' and had given up all expectation of seeing anything. She was ordered two one-grain permanganate of potash pills four times a day, and came unwell a fortnight after, the first time for seventeen months.

We need hardly say that before treating the amenorrhea care should be taken to see that the patient is not pregnant, although we are satisfied that the permanganate given in the dose we recommend has no power to produce abortion either in the early or late stages of pregnancy. We find that manganese fails to induce the flow when the amenorrhea is due to advanced phthisis. But in some cases of arrested phthisis the treatment was successful, and the patient, after a time, under the influence of the permanganate, menstruated freely and at regular intervals. In several instances patients informed us that the pills had proved of value in curing 'whites' of long standing. As a rule the permanganate is taken without difficulty, but patients much prefer the pills to the solution. The solution is peculiarly disagreeable to take, and in some cases produces nausea and even vomiting. Patients frequently complained after taking the pills of a heavy persistent pain over the upper part of the sternum, 'as if something had stuck there and would not go down.' This was not due to the drug being given in the form of a pill, for the same complaint was made when the same dose was given in solution. One patient said the pain was of a burning character, and another said it was like heartburn. A girl of sixteen, to whom two two-grain permanganate of potash pills were given four times a day, said the pain, 'like a lump at the chest,' came on immediately after each dose, and was so intense that she had to go to bed for two hours. That the effects we have described are due to the manganese, and not to the potash in the salt, is shown by the fact that manganate of soda and binoxide of manganese are equally efficacious in the treatment of amenorrhea. The manganate of soda was given in two-grain pills, two four times a day; and the binoxide in four-grain pills, one four times a day. It may be thought that the manganese acts by improving the condition of the blood, but this is not the case. The treatment succeeds equally well in the plethoric and in the anemic. Given in cases of chlorosis, the permanganate not infrequently brings on the period without in any way improving the anemia."—*Lancet*, Jan. 6, 1883.

BREAKING STRAIN OR TENSILE STRENGTH OF THE UMBILICAL CORD.—

Dr. Neville after 123 experiments made by him on the fresh cords of full-time children, in which only the 12 or 14 inches of the cord nearest to the placenta were tested, states his conclusions as follows: In 100 cords, from which the blood had been allowed in great part to escape, before subjecting them to strain, the average tensile strength amounted to 12.5 lbs.; one cord bore a strain of 27 lbs.; nine cords, a strain varying from 20 to 25 lbs.; eighteen, of from 15 to 20 lbs.; forty-eight, of from 10 to 15 lbs.; twenty-three, of from 5 to 10 lbs.; and one of less than 5 lbs. In the case of 25 cords tested, without allowing any escape of the blood contained in them, the average breaking strain was found to be very little above 11 lbs., or nearly one and a half pounds less than in the other case. The cords belonging to male were found to have an average strength of 1.5 lbs. more than those of female children; multiparity made no appreciable difference in strength. The strain was always gradually increased until the cord broke; and rupture was most commonly found to be first marked on the outer aspect of the cord, where an umbilical vein projected in a varicose manner. Thin, straight, and wiry cords, possessing a comparatively small amount of Whartonian jelly, and whose surfaces were least marked by varicose projections, habitually bore the greatest strains. Dr. Neville also considers the question of a gradual drag as affecting in version of the uterus. Assuming, as conditions, a strong funis abutting at or near the center of the fundus on a firmly adherent placenta, and a flaccid pliable uterus wanting in contraction and reaction, he thinks improper traction on the cord very likely to terminate in inversion. Inversion is a rare accident, because these conditions are rarely met with in combination, and because real fundal attachment of the placenta is particularly uncommon, notwithstanding text-book statements to the contrary.—*Brit. Medical Journal*.

FREQUENCY OF DISEASE OF THE SEXUAL ORGANS IN INSANE WOMEN.—

Dr. Danillo examined 200 insane women, and found that 162, or 80 per cent. were suffering from various diseases of the sexual organs. Out of 149 menstruating women, between 15 and 45 years of age, only 20 were without some uterine anomaly. Out of 60 women who had ceased menstruating, between 42 and 75 years of age, 18 were the subjects of some affection of the genital organs. Acute and chronic endometritis and metritis were most frequently observed; less frequently displacement of the uterus, dysmenorrhœa, acute and chronic ovaritis, and other diseases. The above results show that the complications of psychosis with uterine disease is a frequent occurrence, and of the greatest clinical interest.—*London Med. Record*.

TREATMENT OF EPILEPSY. (Dr. Radcliffe in the *Practitioner*.) I have always found that bromide of potassium does not act kindly in cases where the memory is bad and the mental power generally enfeebled; the mischief done, as a rule, showing itself chiefly in stultification and in disfigurement of the skin, by rashes of various sorts, without any very certain change for the better on the attacks. I have indeed found that the attacks were less likely to be kept in check if the bromide was pushed to the extent of causing any stultification or much cutaneous disfigurement, and that it was never advisable to go so far as to produce "bromism," which to my mind, is an evil which is scarcely less ghastly than epilepsy itself. I am quite satisfied that harm rather than good is done by giving large doses of bromide of potassium or bromide of ammonia in ordinary cases of epilepsy where the memory is bad and the mental power generally enfeebled, and that forty-five grains in the course of the day is too large a dose. In a word, the conclusion at which I have arrived is that in any case the bromide has been pushed too far if it gives rise to any marked symptoms of "bromism," that in cases of *le haut mal* with much mental enfeeblement this medicine is very likely to be hurtful even when only given in moderate doses, and that in the majority of cases of *le petit mal* the good to be done by it is barely appreciable.

Bromide of potassium, bromide of ammonia, and bromide of sodium—the three bromides most commonly in use, singly or together,—appear to be very much on a par as to remedial value. I am constantly ringing changes upon the three, without any good reason it may be for doing so. On the whole I am most disposed to use the bromide of ammonium as the least likely of the three to stultify and to disfigure the skin, and also as containing more bromine, for on looking at the equivalents of these three bromides it is found that the quantity of bromine is eighty to eighteen in bromide of ammonium, eighty to thirty-nine in bromide of potassium, and eighty to twenty-three in bromide of sodium.

Of the bromide of iron—which is the only other bromide of which I have any practical knowledge—I have to say only this: Since the delivery of the Gulstonian Lectures, in which I spoke unfavorably of the action of this medicine, I have never given it a trial, but in the interval I have had abundant proof that the good to be got out of the bromides of potassium, or ammonium, or sodium is not unfrequently counteracted by the addition of any proportion of iron. In fact, I do not know where to turn in order to find any reason for believing that iron may ever be advantageously associated with the ordinary bromides in the treatment of epilepsy. On

the contrary, I am continually meeting with some patient who is manifestly benefited by leaving off the iron which he has been taking along with bromide of potassium, or ammonium, or sodium, and who, without the iron, requires less bromide to control the attacks to the same degree. Upon this point I have no manner of doubt.

About the advantages of associating iodide of potassium and bicarbonate of potash with the ordinary bromides in the treatment of epilepsy, I cannot speak so positively as about the disadvantages of associating iron with them. So far as I can judge from what I have seen in the practice, the beneficial action of the ordinary bromides is enhanced by the addition of iodide of potassium and bicarbonate of potash in cases where the memory is good and the appetite for food a little too good. In other words, I am inclined to think that less bromide will serve to produce a good result with this addition than without it.

Among the other medicines which may be advantageously associated with the ordinary bromides in the treatment of epilepsy, those which seem to me to be most deserving of honorable mention are, arsenic, hypophosphite of soda, and chloride of ammonium.

All along I have been in the habit of using arsenic in many cases of epilepsy, with a view to prevent the skin disorder which is so easily produced by the use of the bromides, and partly as an anti-periodic tonic of the highest order of merit. I have an impression, amounting almost to a conviction, that the epileptic is often benefited by arsenic in very much in the same way as that in which the aguish and neuralgic patient is usually benefited. At all events, I am quite sure that many epileptics, who cannot get on without the help of the bromides and who do not take kindly to these medicines, take more kindly to them, and can do with less, when arsenic is judiciously administered along with them. Nay, I may safely go farther than this, and say that there are many cases of epilepsy, among which are very many cases of *le petit mal*, in which the treatment which seems to answer best is a course of arsenic in very small doses with little or no bromide. I cannot say that the action of the arsenic is always beneficial, but I can say without hesitation that it is never hurtful, as iron seems to be always, and that it is generally beneficial if proper care be taken to give it in very small doses, say two or three minims of Fowler's solution for an adult, to suspend it whenever the stomach and bowels are out of order, and never push it too far.

I scarcely know when I began to use hypophosphite of soda in the treatment of epilepsy. At first I gave it for the sake of the phosphorus ;

afterwards for the sake of the soda contained in it. By the phosphorus I hoped to invigorate nerve-power by supplying an important ingredient in nerve-tissue; by the alkali I hoped to work a change in the blood analogous to that which is brought about by the administration of bicarbonate of potash with iodide of potassium, and I have yet to learn that I was wrong in reasoning in this way and in acting accordingly. At all events, I have for years been in the habit of giving hypophosphite of soda in many cases of epilepsy, sometimes along with the bromide, and sometimes by itself, and generally with what seemed to me to be very satisfactory results. Indeed, I do not hesitate to say that the bromide often seems to be almost doubled in remedial value when it is given along with the hypophosphite, or that often thirty grains of the bromide along with thirty grains of hypophosphite, given in one or two doses in the course of twenty-four hours, will go as far in controlling the attacks as forty-five grains of the bromide given by itself. And this is no small gain, for by diminishing the dose of the bromide the risk of stultifying and disfiguring the patient is to that degree diminished.

Chloride of ammonium, from fifteen to twenty grains in the course of the twenty-four hours, acts in very much the same way as the bicarbonate and iodide, and is a little less likely to overtax the vital energy of the patient. Only this very day, for example, an epileptic who had been taking bromide of ammonium with tolerable regularity during the last five years, sometimes by itself, sometimes along with bicarbonate of potash and iodide of potassium, and sometimes along with chloride of ammonium, told me that he always "got on best" when he was taking the bromide in the latter combination. And this patient is only one of many who have come to the same conclusion.

It is, I think, a mistake to be too ready to associate tonics and restoratives with the bromides in the treatment of epilepsy. When a tonic is wanted, as will happen now and then, quinine or bark or nux-vomica, the latter more especially, may, I think, be tried with advantage for a time. When a restorative is wanted, as will also happen occasionally, the choice, I also think, may properly fall upon more than one. Sal volatile or sesqui-carbonate of ammonia is often used, and so is Hoffmann's anodyne, and with excellent results; but the restorative which pleases me most is a dessertspoonful of brandy or rum or whisky in the dose of medicine, or else a capsule containing a drop of enanthic ether after it. I prefer this capsule where the question of cost need not be considered, for I do not wish to encourage the habit of depending upon alcohol. I also prefer it be-

cause the restorative action of this ether is far more persistent than that of alcohol or any other ether. In the course of my professional life I have seen many cases of epilepsy in which a fair trial has been given to zinc, copper, silver, turpentine, naphtha, camphor, quinine, strychnia, valerian, wormwood, stramonium, henbane, foxglove, hemlock, opium, morphia, cannabis indica, cotyledon umbilicus, selinum palustre, indigo, poudre de Neuchatel, chloroform, nitrite of amyl, tracheotomy, trephining the skull, excising cicatrices, cauterising the larynx, and other parts, blisters, setons, issues, and to various other medicines and measures, and on reviewing my experience in these matters, I fail to find anything anywhere which is calculated to enlist my confidence. I could mention not a few cases in which a strong faith in some particular medicine, or measure, or man, has worked wonders. I could tell, for example, of an epileptic young woman, well known to me in schoolboy days, who had had frequent fits all her life, and who was cured by wearing over her heart for two years a charm in the form of a small black silk package, which was an important source of income to an old woman living in the same village, and which, after the death of its proprietor, was found to contain nothing more wonderful than an old prescription by Mr. Abernethy. And I strongly suspect that without faith, much faith, the good to be got out of any of these medicines or measures, with the exception perhaps of occasional blisters or cauterisation, is not worth mentioning. At all events, I do not hesitate to say that there is no one among them which is at all comparable in remedial value to the course of treatment about which I have been speaking.

In dealing with the fit itself, it is, I think, a great mistake to raise the head. The head is raised on the supposition that the fit is caused by a rush of blood to the head, and this supposition is in no way defensible. During the fit the supply of red blood to the head is cut off by an arrest of the breathing; and on theoretical grounds, therefore, what ought to be done is to keep the head down rather than to raise it up. And that is the right practice I am quite satisfied, for again and again I have cut short a succession of fits in an epileptic by taking away a pillow, or by letting the head fall over the edge of the bed, or by raising the arms and legs so as to divert the course of the blood from them towards the brain. I do not say that no good is to be done by compressing the carotids, but this I say,—that if good is to be done by acting in this way, it is only by lessening the supply of *black* blood to the brain and not by lessening the supply of red blood. Nor, so far as I can see, is anything to be said in favor of the practice of fighting against the convulsions by force, or by

sousing the patient with cold water, or by excoriating his nose and lips with smelling-salts. Indeed, all that need be done, so far as I can see, is, to unloose the neckerchief and shirt collar, to lower the head, to prevent the patient from injuring himself by gentle means, and to wait patiently until the fit is brought to an end by the cessation of the process of suffocation, which cessation happens as a rule in a minute and a half or a couple of minutes, and is not to be expedited by any course of procedure with which I am acquainted.

I hold it to be a mistake—the greatest of all mistakes—to suppose that in epilepsy the *mind* ought to be allowed to lie fallow, and the *muscles* put in action in every possible way. I have always thought that education and regular occupation of one sort or another were the true basis of any successful plan of treatment, and all I have seen from the beginning of my professional life to the present day has only served to convince me that I was not wrong in so thinking and saying. By all means let all be done that can be done to improve the general health by exercise of various sorts—by gymnastic exercises, which expand the chest, more especially—but never let it be supposed that education and occupation are not of paramount importance. Don't "put the cart before the horse." Indeed, so strongly do I feel upon this point, that I never care to be responsible for the welfare of an epileptic whose mind, in spite of all I can say, is allowed to lie fallow.

And, lastly, I think it very probable that the epileptic is often prejudiced by being allowed to indulge too much in sleep. The most frequent time for the attack is in bed or in getting up after a long night spent in sleep. And why? Is it that too much sleep has helped to bring about the fit by stultifying the patient? Too much sleep has a stultifying effect, and it is the stupid epileptic who is most likely to have frequent attacks: upon these points all are agreed. Whether what may be said of the stupid epileptic may also be said of the sleepy epileptic remains to be seen. I think it may: at all events, I am sure of this—that attacks which happen during sleep, or shortly after getting up in the morning, are often put a stop to or diminished in number and severity by shortening the hours spent in sleep.

SIC TRANSIT BACTERIA.—The professional mind has for some years been in a feverish condition of hope created by the developments, and their possibilities, in connection with bacteria. It has felt that it was on the confines of some great scientific fact which should be utilized with in-

calculable service, in the healing of the nations. The eye of expectancy has been directed toward the Pasteurs, the Tommasi-Crudellis, the Kochs, the Woods, the Formads and the Sternbergs, who have conducted us to heights from which we have been well nigh able to discern the promised land. If there was a hypothesis in medicine which ever gave promise of blossoming forth into a demonstrable fact, it was the hypothesis that many of our diseases, at least, are due to the introduction into the system of bacilli, micrococci, or bacteria, and the aim of medicine has for some time been to discover an agent which should destroy these and be at the same time innocuous to the system. We are now, however, advised that one of the explorers in this field, Dr. Formad, of Philadelphia, has repudiated his conclusions. It will be remembered that Dr. F., in connection with Dr. H. C. Wood, conducted a series of observations and experiments with membrane secured from cases occurring during the diphtheria endemic at Ludington, in this state, about a year ago. The conclusions were that diphtheria was due to the deposit of a specific parasite on the surface of the buccal cavity, where it found soil favorable to its growth and development. The experiments which led to this conclusion were so carefully conducted and so convincing that they were endorsed by the National Board of Health. Dr. Formad has been active ever since with a view to utilizing his supposed discovery, but the result of his subsequent observation and experiments has been to upset his former convictions. He now declares that bacteria are not abnormalities, but that they exist in all nature and the most they do is to act as poison-bearers. He has found that after a thorough washing in plain water the diphtheria bacillus, so called, becomes perfectly innocuous, thus showing that the diphtheria poison exists merely on the surface of the bacillus and that the latter is not, in itself, the virus. He has found, also, that the sputa of non-phthysical persons contain bacilli identical with those described by Koch, and by the latter regarded as the specific cause of consumption.

These latest declarations will, doubtless, create another very considerable agitation in scientific circles. Let us hope that the result of these advances and repulses may yet be progress.—*Louisville Med. News.*

A CONVENIENT and delicate test for albumen is suggested by Dr. Abbott, of Minneapolis, as follows: Pour a few drops of urine gently down the inside of a glass vessel, containing acidulated water at the boiling point. If albumen be present, a more or less dense cloud will form just at the dividing line between the fluid tested and the clear water above.—*N. W. Lancet.*

DIALYZED IRON.—Dr. Prosser James has lately said, in a summary of the position which dialyzed iron is entitled to hold in medicine, that the persalts of iron are frequently employed solely on account of their astringency, while the protosalts are occasionally considered as being destitute of this quality. The freshly-prepared carbonate is an excellent mild chalybeate, but difficult to keep in an unaltered state, so that preference is given to reduced iron. The scale preparations of iron are held in repute, both from the extreme facility of their use, and their agreeable taste. When these three forms of iron are inadmissible, dialyzed iron may be resorted to with admirable effect. It is a milder chalybeate than the three preceding, and does not produce the slightest irritation.

A recent analysis by Professor Tichborne of Wyeth's preparation agrees almost exactly with Graham's statement, that dialyzed iron contains 98.5 parts of the oxide and 1.5 parts of hydrochloric acid. The liquid thus obtained differs altogether from an ordinary solution of salts of iron, by its not giving rise to the blood-red color on the addition of alkaline sulphocyanide, nor to the blue precipitate with ferrocyanide of potassium. It does not become cloudy on boiling, nor when agitated with two parts of ether and one part of alcohol is the ether layer colored yellow. It is so sensitive that ordinary spring water will cause a precipitate, yet no precipitate is produced by nitric, acetic, or muriatic acid. Graham's solution gelatinized in about twenty days, and he regarded it as a solution of colloid ferric hydrate which, he considered, never existed in both a soluble and insoluble form. It is, however, never free from chlorine. Theoretically, therefore, the liquid is a solution of a basic oxychloride, but it can never be imitated by dissolving saturated solutions of the hydrate. All these artificially-made liquors are astringent, with ferruginous taste and acid reaction.

Respecting the therapeutic value of dialyzed iron, of which there has lately been some inclination to doubt, Dr. James says there is no question. By the method now followed of counting blood-corpuscles, it is found that the taking of dialyzed iron both increases their number and improves their condition. Dr. James gives, as an average dose, twenty to fifty drops, daily, in three doses. Dr. Weir Mitchell, of Philadelphia, gives as much as a drachm at a time.

Specimens have appeared in the market which are not only innocent of any acquaintance with a dialyzing membrane, but seem little else than diluted solution of perchloride of iron.—*Chem. and Drugg.*

LEFT-SIDE PAIN.—At a large meeting of the Academy of Medicine in Ireland, Dr. Wallace Beatty read a paper (*Lancet*) on the Causation of Left-side Pain, drawing special attention to a form not sufficiently recognized, which is due to a fecal accumulation, and removed by getting rid of the accumulation. The pain is felt over the lower ribs on the left side, is associated with extreme tenderness on pressure upward of the tenth or eleventh rib, scarcely any pain being felt on pressure of these ribs downward, and is relieved when the side is pressed inward with the flat of the hand. He explains its occurrence by the drag of a loaded colon on the pleuro-colic ligament; this constant drag setting up a state of extreme irritability in the nerves of that ligament, so that a painful impression is carried upward along the lesser splanchnic nerve to the spinal cord, and is transferred by the law of irradiation to the tenth and eleventh left intercostal nerves. Dr. Beatty did not consider left-side pain to be caused in every instance by fecal accumulation, but only in cases presenting the symptoms mentioned.

THE PREPARATIONS OF ACONITE.—Dr. Squibb, in his *Ephemeris*, states that the fluid extract of the root is the best preparation for internal use. The dose is one minim every three hours, or oftener. For external use there is probably no better form than an oleate of aconitia, made by dissolving two grains of aconitia in ninety-eight grains of oleic acid. A fluid ounce of oleic acid, weighing 412 grains, requires 8.25 grains of aconitia to make a 2 per cent. solution, each minim of which contains about one-sixtieth of a grain. This quantity, applied locally, is a sufficient dose, and should in a short time produce constitutional effects by absorption. It should be applied to the surface by the cork of the phial or by some non-absorbent, and about the head and face needs no covering, great care being taken that it does not get into the eyes. If applied under the clothing it should be covered with oiled silk or rubber tissue. Local neuralgias are much better reached by the dermic or epidermic method.
—*Med. Record.*

QUININE AND POTASSIUM CHLORATE IN MALARIA.—Dr. Baldini (of Grado, west coast of Africa) reports that he has in over seventy cases of intermittent fever cut short the attack as with one blow by using these drugs in combination. He gives for a dose twenty to thirty grains of sulphate of quinine, with fifteen grains of potassium chlorate in a number of pills. For children he suspends the powders in milk.—(*Med. chir. Rundschau, Practitioner.*)

TREATMENT OF EPILEPSY.—At the St. Anne Asylum, under the care of Dr. Ball, the alkaline bromides are generally used, especially the ammonium salt. The following formula is given :

R Ammonii bromidi,
Sodii bromidi, aa ʒiis ;
Aquae, ʒij. —M.

A dessertspoonful to be taken in a cup of a weak infusion of valerian.

Of the above, four doses a day are used at the beginning, gradually increased to eight or ten if necessary.

In obstinate cases, the following pill—

R Ext. belladonnae,
Zinci oxidi, aa gr. xv.

M. et in pil. no. 40 divid.—

may be given morning and evening.

Purgatives may also be need, either as revulsives or to remove irritating substances, worms, etc., from the alimentary canal. Dr. Ball orders the following :

R Aloes socotrin., gr. xv ;
Resinae scammonii,
Resinae jalapae,
Hydrarg. chlorid. mitis, aa gr. viii.
Saponis (amygdalin.), q. s.

M. Ft. pil. no. 24. Of these, three are to be taken night and morning, once a week.

The bromides of ammonium and sodium are preferred, they being well suited for this purpose by the great facility with which they are tolerated, even in large doses, by their prompt and sustained effect, by the absence of all phenomena of depression, and, finally, by the services which they are able to render in the cases where the bromide of potassium is without effect.—*Revue de Therapeutique.*

COSMOLINE AND PETROLEUM IN DIPHTHERIA, HOOPING-COUGH AND MEASLES.—Dr. Harvey L. Byrd, in the *Medical News*, says: I have been using petroleum locally to the throat for some time past, while administering cosmoline internally, as a remedy in diphtheria. They are

both remedies and prophylactics in this terrible scourge. I administer cosmoline alone in alternation with lac sulphuris, or in conjunction with it, in eight to fifteen-grain doses of each, according to the age of the child, every two or four hours, while petroleum is applied to the throat externally. But while I regard it as the chief factor in producing relief in diphtheria, the gravity of the disease is such that I have refrained from relying upon its internal use to the exclusion of other remedial agents. I recommend the administration of cosmoline twice a day to the well children of a family, as soon as called to a case, with the result of protecting all those from the disease who have taken it. Its action has been highly satisfactory in whooping-cough and measles. Cosmoline will lessen the violence of the paroxysm in whooping-cough, and loosen as well as lessen, the mucus promptly, and it mitigates the violence of the attack and shortens the general course of the disease.

AN ANTI-QUACK WRAPPER.—Dr. F. H. Darby, of Morrow Ohio, furnishes a four-paged and double-columned sheet wrapper, filled with useful information for the sick ; designed for druggists, or for physicians who dispense their own medicine. It is so arranged that it can be torn into halves, quarters, eighths or sixteenths, without marring the printed matter. The paragraphs comprise abbreviations of that portion of the Code of Ethics relating to the duties of patients to their physicians, useful receipts, etc. These wrappers can be supplied at a very nominal cost, and the idea of their use seems to be a good one.

SURGERY.

SOME POINTS IN THE REDUCTION OF HERNIA.—The method of taxis for reducing a hernia, especially one that is strangulated, adopted and advised by Prof. J. S. Wright, of Brooklyn (*Proceedings*), may be described as follows:

1. As far as possible grasp the hernial tumor with one hand; this can generally be readily done, except when the tumor is very large. The right hand will be the best adapted for this purpose.

2. Now take hold of the neck of the hernial sac with the thumb and fingers of the left hand, in close proximity to the ring of constricting tissues, which can generally be readily distinguished.

3. Then make gentle traction on the hernial tumor by means of the right hand, when two effects will generally supervene: (1) The hernia will be drawn out a little and liberated from the ring of the constricting tissues; and (2) Some of the fluid contents, and may be some of the solid contents, of the sac, may be felt going through the hernial canal into the abdominal cavity. As the hand pulls on the tumor, it will compress it at the same time, and thus tend to express the contents of the sac. And the contents of the sac will be more apt to be expressed because the hernia is liberated from its constriction.

4. The thumb and fingers of the left hand, as it were, supplement the hernial canal, as they are near the constricting tissues, so that the sac and its contents will be prevented from expanding just outside of the outer end of the hernial canal. In one instance the thumb and fingers will accurately guide the hernial contents into the hernial canal, and in the other instance the hernial contents will swell out around the outer end of the hernial canal. In the latter instance the reduction of the dislocated intestine will be obstructed, and in the former instance its reduction will be greatly facilitated.

5. When the fluid contents of the sac begin to *go back*, then the solid contents of the sac will also begin to *go back*. The left hand of the surgeon must still continue the work it has begun, but the right hand must now, in addition to firmly grasping the hernial tumor, begin to push this tumor toward the external ring, in between the grasp of the thumb and fingers of the left hand, when generally, little by little, and sometimes

suddenly, the dislocated intestine will be reduced. Of course, the rules of position and relaxation in regard to the patient should be put in force. When this method of taxis is properly carried out, it will, no doubt, diminish the number of operations for strangulated hernia.

6. In this place I may draw attention to this method of taxis, for the purpose of reducing a hernia when the minor operation is performed, since the constriction may be outside of the neck of the sac. Also I may call attention to the fact that I have sometimes expanded and stretched, or, perhaps, torn more or less, the constricting band of tissues about the neck of the sac, by means of my finger, which has been pushed up under the edge of this band, carrying the tegumentary tissues before it, thus enabling me to reduce a hernia because the canal has been enlarged. At times I have found this a most valuable expedient, and have never known it do any harm.

ENLARGED TONSILS.—Dr. Gordon Holmes, in discussing the treatment of chronic enlarged tonsils, gives his preference to excision by means of the tonsillotomes when there are no manifest contra-indications. Cases are, however, constantly met with in which the child steadfastly refuses to submit to the cutting operation, or in which parents object; or the enlargement may be so great as to render excision necessary. In these the application of caustics is our only resource. Strong solutions of perchloride of iron are useful only in temporary acute engorgement, being absolutely valueless in true hypertrophy. Among caustics, nitrate of silver, chloride of zinc (in stick), Vienna paste, London paste (equal parts of powdered unslacked lime and caustic soda made into a paste with water as required), are those commonly employed. Nitrate of silver is of service only in cases in which the surface of the gland is in a softened and raw state, being useless in reducing the toughened mass of connective tissue which usually constitutes the permanently enlarged tonsil.

There is, however, another method, very much more effective, of applying the common caustics to the tonsil, which appears to have remained hitherto unnoticed. The tonsil, as the anatomist knows, is permeated by several rather large channels around which the follicles are collected, opening on the pharyngeal side of the gland, whence its characteristic cribriform aspect. Their orifices, about seven to fifteen in number, are sufficiently evident to be counted on the healthy tonsil *in situ*, whilst in the hypertrophied condition these lacunæ increase greatly in calibre and

depth, and can be ascertained by a probe to vary from one-eighth of an inch to half an inch in length, with a diameter capable of admitting a style of ordinary size. These observations, then, afford a valuable indication for treatment: for through these natural canals a way lies open for us to attack the heart of the gland in a most efficacious manner with our caustics. Thin, pointed sticks of nitrate of silver or chloride of zinc can easily be pressed into the lacunæ and worked round for a few seconds. Small sloughs are thus formed which are soon discharged, and in the process of this treatment the tonsils are hollowed out in one direction whilst being contracted into much smaller bulk by the subsequent cicatrisation in another. Two or three channels in each tonsil can be cauterized daily or on alternate days, and we can thus act on a comparatively large surface whilst causing but slight external soreness and little or no suffering to the patient. In practicing this method, although the strongest caustics may be used, Dr. Holmes does not think it will be necessary to have recourse to anything more potent than nitrate of silver, which acts much more effectually on the more tender internal structures of the tonsils than when applied to the comparatively callous pharyngeal surface.

The galvano-caustic (a small loop of wire raised to a white heat by electricity as soon as placed in contact with the surface to be cauterized) is a very eligible means of destroying the growth. It kills immediately the part to which it is applied and leaves a clean ulcer, which soon heals almost unfelt by the patient.—*Med. Age.*

HOT WATER IN EPISTAXIS.—M. Auquier mentions a case in which he was called to a young man of twenty who had been suffering for three hours from violent epistaxis. The patient had been subject to such attacks from infancy. M. Auquier tried in vain to stop the bleeding by means of cold water, plugging the nares, mustard plasters, &c. At last he irrigated the nose with very hot water, with instant success. During the next night and day the friends of the youth were able by this means to stop at the outset several fresh outbreaks. The author thinks the hot water acted by producing a reflex contraction of the bleeding vessels; and not by encouraging the flow and so causing depletion of the superficial vessels as has been supposed, in reference to the stoppage of uterine hemorrhage.—(*Gaz. hebdomadaire de Montpellier—Practitioner.*)

CARBOLIC ACID IN TOOTHACHE.—A writer in the *Medical News* (Phil.) speaks very highly of this treatment. He gives the following directions :

1st. Clean out and dry, by means of absorbent cotton, the cavity of the tooth.

2d. Apply the acid thoroughly in the following manner: Take a piece of *wood*, according to the size of the cavity (a toothpick or a match will do), and dip the end into carbolic acid—*full strength*; should the hole be very large, a very small portion of cotton may be twisted around the end of the piece of wood. Care is required not to touch the surrounding tissues. It is scarcely needful to add that the acid crystals only need to be warmed to render them soluble.

The foregoing applies especially to odontalgia cariosa, and to odontitis; but it will also prove serviceable where the fangs of the tooth are affected especially if they are accessibly exposed.

NUT IN TRACHEA EIGHTEEN DAYS; DEATH.—Dr. James H. Warren reports this case in the *College and Clinical Record*. The foreign body was a beech-nut. The Doctor desired to operate for the removal of the nut, but the friends would not consent. At the autopsy the nut was found imbedded, by its edges, in the trachea just below the larynx. Death was due to double lobar pneumonia.

MILDER TREATMENT OF GONORRHEA.—Dr. J. H. Warren, of Boston, has a timely "plea" for a change in this direction in the *Phil. Med. and Surg. Reporter*. He recommends washing the urethra out with *hot* water, used copiously; if desired, this water can be medicated by the addition of tannate of lead, twenty grains to the quart. Keep the bowels open with salines, or compound licorice powder. For gleet, he uses his vermicular sound, medicated with carbolized iodoform ointment. Bromide of sodium he regards as almost a specific for urethral or uterine irritation, in doses of x—xv grains.

REVIEWS AND BOOK NOTICES.

Prices are always inserted when furnished by the publisher, or when obtainable from the bookseller.

Fourth Annual Medical Report of St. Elizabeth Hospital, Dayton, Ohio, under the charge of the Sisters of the Poor of St. Francis, for the year ending December 31, 1882.

Dayton is certainly to be congratulated over her elegant new Hospital, which, as we learn, has a frontage of 158 feet, a depth of 90 feet, and a height of four and five stories, besides the basement. Its capacity is 200 beds.

There were treated during the year 384 patients. Thirty-seven operations were performed, including one successful ovariectomy. The "Tabulated Statement of Diseases" is somewhat of a curiosity: Among "general diseases" we find cancer of stomach, of the breast, &c., while among "local diseases" are epilepsy, neuralgia, melancholia, &c.; chronic nephritis is under "diseases of the generative system," while under those of the "cutaneous system" come abscesses of the knee and hip; a fracture of a rib is classed under "general injuries," while a fracture of the skull is "local," and a gunshot wound of the abdomen is "general," while a similar wound of the brain is "local."

A Guide to Therapeutics and Materia Medica. By Robert Farquharson, M. D., Edin., F. R. C. P. Lond., etc. Third American edition, revised by the author. Enlarged and adapted to the U. S. Pharmacopeia by Frank Woodbury, M. D., Physician to the General Hospital, Philadelphia. Philadelphia, Henry C. Lea's Son & Co. 1882. Pp. 526; 8vo.; cloth, \$2.25.

In this edition, the text has been thoroughly revised and brought up to date. Among the new subjects introduced in this edition are: Resorcin, Chinolin, Quebracho, Duboisia, Pelletierine, Muscarin, Cosmoline, Fuchsin, and others. In order to accommodate this matter the work has been enlarged. The peculiar features which have made this book deservedly popular has been retained, viz.: The discussion of the physiological and therapeutical effects of each remedy in parallel columns; the complete list of official preparation (U. S. P.) the brief analyses of toxicological effects, and antidotes; the writing of prescriptions; and the remarks upon practical therapeutics, and the most desirable methods of drug administration. It is throughout complete in all the necessary details, and clear and lucid in its explanations.

A third edition of "*The Physician Himself*," is announced. We have already noticed the preceding editions of this excellent little work, and can recommend it to all. D. W. Cathell, M. D., Baltimore, Md.

The Compend of Anatomy, for use in the dissecting room, and in preparing for examinations, by John B. Roberts, M. D., Lecturer on Anatomy and Operative Surgery in the Philadelphia School of Anatomy, late Demonstrator of Anatomy in the Philadelphia Dental College, etc. Third edition. C. C. Roberts & Company, 1118 Arch Street, 1882.

The third edition of this excellent aid to students is on our table. The fact of its running through three editions is incontestable proof of the popularity it has won for itself, and a strong recommendation to all who require such a compend.

Dr. Henry G. Cornwell, of Columbus, has issued a very complete "Consultation Chart" of the eye symptoms and eye complications in general diseases. It appears to be full and accurate, and well worth the practitioner's attention. Price, 50 cents.

On Asthma; Its Pathology and Treatment. By Henry H. Salter, M. D., F. R. S. First American from the last English edition. New York, William Wood & Co. 1882.

This is the September number of Wood's Library. In all that relates to the clinical history of asthma, its etiology, prognosis and treatment, no better work has been issued in the English language than Salters'. The theories regarding the phenomena of the disease, are dealt with from the standpoints of fact and experience. In the chapters on treatment, the several depressants, stimulants, sedatives, and antispasmodics, their mode of action and relative value, are fully discussed. Diet and hygiene and the influence of locality also receive due consideration. Special appendices are devoted to clinical and tabulated cases.

The Hospital Treatment of Diseases of the Heart and Lungs, with over three hundred and fifty Formulæ and Prescriptions, as exemplified in the Hospitals of New York City. By Charles H. Goodwin, M. D., New York. C. H. Goodwin, M. D.; 1883.—12mo. Pp. 196; cloth, \$1.50.

The author in the preface says: "Among the numerous medical works, there is no book which places before the physician the real practical hospital treatment, founded on the daily experience of the leading medical men of the times, and in the great wards of metropolitan hospitals representing the latest, most improved and successful methods." The present volume contains a resume of the treatment of the diseases of the lungs and heart as exemplified in the various hospitals of New York. It is a concise little work, and will prove convenient for reference.

Legal Medicine. By Charles Meymott Tidy, M. B., F. R. C. S., Master of Surgery, Professor of Chemistry and of Forensic Medicine and Public Health at the London Hospital, etc., etc. Vols. I and II. William Wood & Co., New York. Nos. 56 and 58 Lafayette Place, New York City.

These two volumes are the concluding numbers of Wood's Library of Standard Authors for 1882. Dr. Tidy has long been favorably known as an authority upon the subject of Medical Jurisprudence, the large work, so popularly received by the legal and medical professions, written by him in conjunction with the late Dr. Woodman, having firmly established his reputation in this direction. Vol. I contains chapters on Evidence, the Signs of Death, Identity, Causes of Death, the Post Mortem, Sex, Monstrosities, Hermaphroditism. Vol. II, on Expectation of Life, Presumption of Death and Survivorship, Heat and Cold, Burns and Scalds, Lightning, Explosions, Combustibles and Starvation; each subject is thoroughly considered, and will afford the reader an amount of instruction seldom offered in as many pages. The work will be completed in two more volumes, which will form part of the Library of 1883.

Pocket Therapeutics and Dose Book, with classification and explanation of the actions of medicines; min. and max. doses in troy and metric weights; index of common and pharmaceutical names; index of diseases with appropriate remedies; tables of solubilities; illustrations and examples in prescription writing; poisons, their symptoms, antidotes and treatment; incompatibles and antagonists; useful hints to the prescriber, etc., etc., by Morse Stewart, M. D. Third edition, revised and enlarged. Geo. D. Stewart & Co., Detroit, Mich., November, 1882.

An immense amount of information in the smallest possible space. For reference in emergencies this volume is very desirable.

WOOD'S LIBRARY OF STANDARD MEDICAL AUTHORS FOR 1883.

The volumes selected for publication in 1883 are believed to be equal to any previous series, in point of scientific merit, and will far exceed them all in beauty and excellence of mechanical workmanship. It will continue to be sold as heretofore, by subscription only, at \$15 a year. As these volumes are all new and some of them original works, prepared especially for this Library, it may become necessary, from wholly unforeseen causes, to substitute some other work in place of one or two of the volumes. Such a possibility, however, is less likely to occur this year than

heretofore, every precaution having been taken to ensure the delivery of the manuscripts in season to enable the publishers to issue them as advertised.

II. Manual of Gynecology. By D. Benj. Hart, M. D., F. R. C. P. E. Lecturer on Midwifery and Diseases of Women, School of Medicine, Edinburgh, etc., etc.; and A. H. Barbour, M. A., B. Sc., M. B., Assistant to the Professor of Midwifery, University of Edinburgh. Illustrated with eleven plates, two of which are in colors, and 401 fine wood engravings. In two volumes.

III. Hand-Book of Electro-Therapeutics. By Dr. Wilhelm Erb, Professor in the University of Leipzig. Illustrated by 39 wood engravings.

IV. The Microscope and its Revelations. By Wm. B. Carpenter, C. B., M. D., LL. D., Sixth Edition. Illustrated by one colored and about 26 plain plates, and upwards of 500 fine wood engravings. In two volumes.

VI. Diseases of the Esophagus, Nasal Cavities, and Neck. By Morell Mackenzie, M. D., London, Senior Physician of the Hospital for the Diseases of the Chest and Throat; Lecturer on Diseases of the Throat at London Hospital Medical College, etc. Illustrated by wood engravings.

VII. The Diseases of Women, a Manual for Physicians and Students. By Heinrich Fritsch, M. D., Professor of Gynecology and Obstetrics at the University of Halle. Translated by Isidore Faust. Illustrated with 150 fine wood engravings.

VIII. The Treatment of Wounds. Being a treatise on the principles upon which the treatment of wounds should be founded, and upon the best methods of carrying them into practice, including a consideration of the modifications which special injuries may demand. By Lewis S. Pilcher, A. M., M. D., Brooklyn, N. Y. Illustrated by wood engravings.

IX. Hereditary Syphilis. Its Pathology, Treatment and Differential Diagnosis. By F. R. Sturgis, M. D., Harv., Member of the Academy of Medicine, Ophthalmological Society, Dermatological Society, N. Y. Clinical Society; Visiting Surgeon Charity Hospital, New York, etc. One volume. Illustrated with one chromo-lithograph and several fine wood engravings.

X-XI. Legal Medicine. By Charles Meymott Tidy, M. B., F. C. S., Master of Surgery; Professor of Chemistry and of Forensic Medicine and Public Health at the London Hospital; Medical Officer of Health for Islington; late Deputy Medical Officer of Health and Public Analyst for the City of London, etc. Volumes III and V.

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"A CAD OF A DOCTOR."

"Cad, a vulgar, low bred, pretentious person." (Webster.)

A year or two ago, in one of his delightful letters to the *Philadelphia Medical Times*, Dr. J. Milner Fothergill used our caption as indicative of the position occupied by the English doctors in society, and by so doing he succeeded in raising a tempest in a tea-pot among his local brethren, in which, however, he sustained his position beyond question. That the American doctor occupies a higher position in the social scale than his English *confrere*, will not be claimed by any one.

A few generations ago, medicine was regarded as one of the learned professions, and to belong to it was an honor. At present, however, it is very safe to say that the young doctor starts out with scarcely greater social prestige than the young artisan, clerk or book-keeper, and even less than the manufacturer or merchant, while his lower position, with reference to Theology and Law, goes without saying. He may succeed in advancing himself, but he will accomplish this by his individual tact and acquirements, not by any aid derived from his profession; there is no special presumption in his favor.

The causes which have produced this state of affairs have been at work for a long while. Of these causes two stand out most prominently: First, the entry into the profession of incompetent men, thus directly degrading it; second, the increased intelligence of the laity, by which this incompetence has come to be recognized. Physic, i. e., the giving of drugs to

"cure" disease, thrive best in the midst of ignorance and superstition. As people became intelligent they desired to know what medicine was being given them, and why, and how its effects were supposed to be produced; and when their questions were not answered, or not answered satisfactorily, they became suspicious, and suspicion led to investigation, and investigation to doubt. Homeopathy came, and offered an answer to these investigations—specious, to be sure, but still an answer—and at once met with a warm welcome. Patent medicines also came, and succeeded in silencing all questioning opposition by the brazen effrontery of their preposterous claims. Meanwhile, "regular medicine," "rational medicine," "empirical medicine," plodded on, giving its powders and pills and potions, with no better idea of their action than that possessed by the old woman of the teas which she recommends with such meek assurance and faith; the doctors and the old women all quoting "experience" as their guide, forgetting the utter worthlessness of all ordinary experience, especially when coupled with ignorance.

But it remained for the last few months to put the crown of deepest humiliation and shame upon our profession. Garfield was shot, and at once there was a struggle for the honor of attending him, in which he who was least qualified for the duty—and, as it has since appeared, least desired by the patient—came off victorious. Then there was the long series of criminations and recriminations, in the newspapers, over the diagnosis, prognosis and treatment. Then the post mortem, which brought confusion to the profession as it revealed the gross error in diagnosis. Then the quarrel over the post-mortem; what could the public think of a "science" which was unable to demonstrate whether a blood vessel had been injured by a bullet, eroded by ulceration, softened by pyemia, or burst by the embalmer's syringe!

We turn the page, and read the chapter of Guiteau, and find the usual quarrel of the "experts" over the question of his sanity; we find him dead, and another quarrel over the autopsy; we find his brain submitted to "experts," and another bitter quarrel resulting therefrom.

We turn another page, and find the chief surgeons of the Nation—those to whom we have for years pointed with pride—presenting their bills for services rendered. We find those bills cut down to one fourth the amounts asked for, and our cup of humiliation is full. If the bills were exorbitant and unreasonable, what must be thought of the rank and file of a profession whose leaders would be guilty of such attempted extortion? If the bills were just and reasonable, how low has the profession fallen

that a committee should dare to so scale them, and be sustained in their act by the public press! But there the record stands; the chief surgeons of the Nation, standing at the very head of the profession, placed in compensation on a level with a mere female *nurse*—nurse Edson!

We turn another page—thank God, the last, as yet—and find the leaders of the medical society of the chief State of the Union, representing its great metropolis, and medical centre, deliberately and openly throwing off all restraints of order and decency in order to be able to add a few paltry pence to their purses by associating with professional outcasts and knaves.

As a man is to be known by his associates, the number of young men of education and culture, having spirit and ambition, and possessed of means to enable them to secure all requisite professional education, who will desire to enter upon the study of medicine, must necessarily be small. To be, before the law and the public, merely the equal of the abortionist, the clairvoyant, the herb doctor, and of the man who practices a delusion and trades upon a name; to be compelled to fellowship with men such as Dr. King has exposed in Missouri—and they swarm in every State and community, and no where more than in Ohio; to meet them in consultation, to cover over their errors, excuse their mistakes, and do nothing “which could impair the confidence reposed in them, or effect their reputation” (*Code of Ethics*, Art. IV., § 10.); to be met by them in consultation, and, perhaps, be undermined and supplanted by them; to be called to testify as an expert, and find ones testimony—the fruit of a life-time of study and investigation—set at naught by the flippant evidence of the ignorant and conscienceless “expert” of the opposite side, while the ears tingle at the overheard jestings of the members of the bar—who reflect the sentiments of the community—as to “the price per dozen of doctors as experts;” to be, and to do, and to endure all this, to be a servant of servants, on the go, night and day, sick* or well, for the wages of a working man,† and the honor of being “a cad of a doctor,”—all this does not furnish a pleasing prospect for young men whose natural and acquired advantages lead to aspire to be somewhat above the average, and hence

* “‘Rouse up,’ said members of the family to one of the first physicians of France, then on his couch, sinking under most painful and wasting disease—‘rouse up—a patient is in waiting. Go earn a few francs—there is not any bread in the house!’”—(Dr. Cotting, in *Boston Med. and Surg. Journal*, Nov. 30, '82.)

† “An eminent clergyman told the speaker that he once investigated the incomes of physicians in one of the larger cities, and found that, after deducting expenses necessary to the practice of the profession, they did not annually receive, on an average, more than workmen in the same city.”—*Ibid.*

few such men enter the profession, while of those that do enter it many soon leave it in disgust.

What the end of all this will be, no one can fortell, but the future of the profession is certainly dark, and the physician who recently, in our presence, said he would rather see his son dead than following in his footsteps, but expressed very graphically the sentiments of thousands of his brother practitioners.

PLACENTA PREVIA WITH TWIN PREGNANCY.—Dr. E. P. Bernady (*M. & S. Reporter*), of Philadelphia, reports such a case, which he considers unique.

At a recent meeting of the Central Ohio Medical Society, Dr. Starling Loving, of this city, reported a similar case, which was, however, complicated by the presence of a uterine fibroid, resulting in severe *post partum* hemorrhage, the case concluding with an attack of phlegmasia alba dolens. At the same session, Dr. E. B. Pratt, of Mt. Sterling, reported a case of *triplets*, with placenta previa. Next!

OUR co-Editor, Dr. J. H. Lowman, sailed for Europe on the 17th ult. He expects to be gone four or five months, and will pay especial attention to the diseases of the throat and chest. He promises us an occasional letter. His address will be in care of Brown, Shipley & Co., London.

OBITUARY.

DR. ANDREW McLAUGHLIN, of Tremont City, Ohio, died October 12, 1882, aged 73 years, 2 months, and 11 days.

Dr. McLaughlin located in Tremont City in 1836, after graduating at Starling Medical College. He was an honored member of the State Medical Society, and also of local organizations.

NOTES AND COMMENTS.

SAMPLES OF MISSOURI QUACKERY.

We cull the following gems from Dr. King's address on Quacks and Quackery in Missouri :

An old practitioner said that "Dover's powder was a favorite remedy with him as it would produce a gentle diaphoreus and had a soothin' effect on the mucous membrane of the brain." Explaining vicarious menstruation, the same doctor said, "the blood is stopped in the womb and forced through the fallopian tubes into the lungs."

"Mr. poste master pleas scend my male to the turn back poste Office af you pleas sir Any is in the office for me Dr. J. R. G."

A doctor said that, "as soon as the lochia ceased to flow through the mouth, and were established through the vagina, the convulsions would cease." She had bitten her tongue.

A quack went for a regular physician to operate for strangulated hernia, which he said he had tried for two days to reduce by taxis. But arrangements were not completed before a red-headed boy rode up to the office and said: "You doctors needn't come; Bill only had a bile and it's busted."

A quack rubbed a solution of plumbi acetis on a woman's abdomen, and shortly afterward pulled up the clothing and showing the husband a discharge from the vagina, said, "There, now! don't you see? The medicine is absorbed already."

On being asked as to the health of his neighborhood, one said, "O, sickness is debating." On being further asked how he got along so well with the prevailing fevers, he said, "Well, I'll tell you, but I won't tell them d—d quacks out in the country. I take some soda, and put a little water in one glass, some acid in another; I then pour them together, and let the patient drink it while it is vesicating."

A female doctor was called to see a lady who was suffering from hemorrhage of the kidneys. The doctress stated that she "knew all about it—her father had the same disease—hemorrhage of the prostate gland."

One quack said "he gave the patient a little turpentine as her bowels were a little gastric."

Another told a gentleman who had synovitis of the knee-joint, that "there was a rheumatic worm in the joint eating up the asphaltum."

A root doctor has but three medicines, all made from the same root. He calls them respectively "Hibobalorum, Lobobahirum, and Hi-lo-

bustem." One is a cathartic, another an emetic, another, last, "a rank pizen" which will bust his patients open. He makes the first by peeling the bark downwards, the second by peeling it upward, and the last by peeling it around.

Many pages of Dr. King's address were filled with similar "uncut gems." They are funny—many of them, and serve to excite a laugh, but to an honorable practitioner they cause a blush.

We quote a paragraph or two from his paper :

"The condition of things shown is enough to sicken any man who has any regard for the dignity, standing and honor of our profession ; and is sufficient to alarm and appall any person, not a doctor, who is capable of appreciating the danger in which the community is placed by reason of the presence of many illiterate and incompetent men in their midst assuming to represent our noble profession and to take charge of the issues of life and death.

"The presence of these ignorant pretenders and swindling rascals is a standing cause of shame and annoyance to every worthy, honest and competent physician ; for say what we will the people—the great majority of whom do not seem capable of distinguishing between the true and false in our profession—*will* class us with these creatures and *will* call upon and beg and importune us to meet them in consultation in cases threatening life, and our refusal to do so often puts us at a disadvantage before a community which has more heart than brains."—*Peoria Med. Mo.*

A NECESSITY OF THE DAY.—Few minor inventions have been so readily appreciated and come so quickly into general use as the stylographic pen. None who have used one will ever be contented with any less convenient apparatus for writing, and in a short time there will be few who have occasion to write at all who have not adopted it. The general principle of the stylographic pen is so familiar as to require no explanation. We have made trial of various kinds, but have found none to equal the improved Livermore Stylographic Pen, which combines all the advantages of other makes. It is convenient to use, writes with any kind of good ink, and is practically indestructable. Sold at first for \$3 each, the price has recently been reduced to \$2 for plain pens, with 50 cents extra for gold mounted. By sending that amount to Louis E. Dunlap, Manager Stylographic Pen Company, 290 Washington Street, Boston, a pen, together with a package of superior ink, will be sent by return mail, and the money will be at once refunded if they do not prove to be perfect in every respect.—*Morning Mail, Lowell Mass.*

THE Councillors of the Massachusetts Medical Society have voted that Columbus Medical College be dropped from the list of medical colleges whose diplomas are recognized.—*N. Y. Med. Record, March 17, '83.*

COLUMBUS MEDICAL JOURNAL.

Vol. 1.

APRIL, 1883.

No. 10.

COMMUNICATIONS.

ONE OF THE ABUSES OF CARBOLIC ACID.

WEBB J. KELLY, M. D., INDIANAPOLIS, IND.

“Vice is a discord, war and misery; but virtue is
Peace and happiness and harmony.”—*Shelley*.

Every now and then some accoucheur meets with ill luck, and as a consequence as labor ushers a new soul into this world to battle and brave its hardships, one that has already suffered the pangs of misery and sorrow passes away. Such has been the history of midwifery always, and such will be its history so long as women conceive and bear children. Such accidents are indeed unfortunate—unfortunate for the accoucheur, and unfortunate for the bereaved family; but the greatest misfortune of all is the evil thoughts it causes to arise in the minds of others, who themselves may some day be called upon to pass through the trying and painful ordeal of childbirth. The many times we are called upon in great haste to attend these women, and treat them in the after stages of miscarriage and abortion, only shows the effects of the terrible impression left upon their minds by a childbirth death. I really believe that two-thirds of the abortions produced every day are done more through fear of death during childbirth, than through any other motive.

If we follow into the private chambers of married women, and take a peep into the little dark closet, in how many will we see bottles of ergot, cotton root, savin, oil of tansy, etc., to produce as they call it, “accidental miscarriage?” And when these agents fail, how many times will we find a “reputable and prominent physician” receive a specified sum, and, sound in hand, enter that chamber and induce premature labor! We are all ready to acknowledge that this is the darkest spot in our profession.

These women are in reality the worst set of patients the profession has to contend with. Still there is another class, who in my opinion suffer more than these; they are those who endeavor to prevent conception. If you have never kept a record of the number of cases of "nervous patients" you treat annually, whose affection is induced by this one thing, do so, and see how great will be your surprise at the end of the year. Of course this is an old story to many of the older practitioners, especially in the cities, but it may be new to some of the younger members of the profession.

During the last two years I have met with three very interesting cases of this kind, where the nervous irritation and the accompanying symptoms were caused from vaginal injections of carbolized water, to prevent conception, and as the recital of them may lead to further investigation of the subject, it affords me great pleasure to be able to give the history of each case.

Case I. Mary H—; aged twenty-three years; dark eyes and hair; plump, well formed girl; always been very healthy until within the last few months; has led a prostitute life for about two years, and is now an inmate of a house of ill-fame.

When I first saw her she was suffering from extreme nervous prostration, with the following symptoms: Extreme irritability of the stomach, accompanied with some pain in that region; skin cold and clammy; great headache, particularly at the base of the skull; pupils contracted; pulse weak and thready, with slight intermittency; slight diarrhea; temperature, $97\frac{5}{8}$; extreme nervousness; on attempting to walk across the floor her limbs give away and refuse to support her; she has eaten nothing for twenty-four hours. I confess I was somewhat embarrassed in my diagnosis, and had she not assisted me would have made an utter failure of it. It seems that the girls in the house were in the habit of using vaginal injections of carbolized water for the double purpose of preventing conception and of avoiding venereal diseases. It was not an uncommon occurrence for them to suffer as was she at the present time, only in a much more sub-acute form. At these times they would dispense with the carbolic acid. The only medicine they would take was quinine, which seemed to have the desired effect of dispelling all symptoms of poisoning. She had been warned several days previous to give up the acid, but circumstances being such that she thought it was a necessity, she continued in its use. With good care and proper medication she made a good recovery.

Case II. Shortly afterwards, I was called upon to prescribe for Mrs. ———; aged 39 years; very dark complexion; medium size; mother of five children. Ever since the birth of the youngest child, four years, she has been an invalid more or less all the time. Her physician claimed that she was suffering from womb disease, the result of the last confinement. By inquiring I ascertained that with the exception of the child being very large there was nothing unusual transpired at that time. She presented the following symptoms: Extreme nervousness; could stand very little physical labor; her skin was of a yellowish cast; she complained of a constant pain in the back part of her head, and also a "giving way" in the small of the back; no appetite; the least excitement would throw her into hysterics; she suffered terribly from melancholia; there was positively nothing wrong with the womb. I then ascertained that shortly after the birth of her child, a neighbor woman died during child-birth, and this so impressed her that she sought the advice of a noted quack in Cleveland, Ohio, who, with all the impressiveness of such individuals, gravely informed her should she again become pregnant her life would surely pay the penalty, but if she would freely use vaginal injections of strong carbolized water there would be absolutely no danger. From thence dates her misery. I gave her treatment for some time with, apparently, no good effect, and finally, as a last resort, sent her away from "home and husband." While away she steadily improved, and came home almost well, only to relapse in a short time into the old state of health. This was because she would not give up the use of the acid. Recently she gave it up, since which time she has improved wonderfully, and, I think, will entirely recover her health.

Case III. Mrs. K———; aged 20 years; slight build; dark eyes and hair; married about one year. Her symptoms were very much like the previous case, only in a milder form. She used the acid on the advice of her mother (case second). Nothing seemed to do her any good, as she continued in the use of the injections—using, on an average, four ounces of acid a week. Circumstances taking place which compelled the separation of husband and wife, permanently, she began to improve, and a recent letter from her states that she has completely recovered her health.

In this report I shall not attempt to discuss the action of carbolic acid on the nervous system, nor on any particular set of nerves, but this I will say: Carbolic acid used for any length of time in vaginal injections, for the prevention of conception, will give rise to symptoms of chronic poisoning by this acid, and if too freely and frequently used will give the acute symptoms.

[Since writing the above I have met with one more case: Mollie D——; aged 28 years; dark eyes; strong, healthy woman; prostitute, Suffering from mild poisoning. In this case the vaginal walls suffered from the caustic effects of the acid.]

IDENTITY OR NON-IDENTITY OF CROUP AND DIPHTHERIA.

Remarks made before the Central Ohio Medical Society:

DR. H. J. SHARP, OF LONDON.

I believe diphtheria to be distinct and altogether a different disease from pseudo-membranous croup, or what I would prefer to call acute membranous laryngitis, for, I agree with others in considering the term croup as a misnomer, when applied to a disease. Moreover, I not only believe them to be distinct diseases, but that the treatment of the two diseases will be successful or otherwise, accordingly as to whether or not the physician bases it upon this view.

In all that Dr. Pooley has said it seems apparent, that his opinions, like those who adhere to the identity of these diseases, have been formed from the standpoint of the anatomist and microscopist, more than from that of the clinician, and were I to draw my conclusions from anything that has been discovered by the most careful investigation into the morbid anatomy of the disease by aid of the microscope, I would find little difficulty in agreeing with such opinions, for the most careful investigations prosecuted to this end, have failed to demonstrate conclusively that they are not identical, if we accept the conclusions of Oertel and those of his school of belief, who ascribe diphtheria to bacterian origin, and hold in this that it is distinct from what is ordinarily known as croup.

Whatever my opinion, as viewed from the standpoint of the anatomist and microscopist, as to the identity or non-identity of the two diseases, may have been, when studied at the bedside I have been compelled to regard them as very different diseases, and my treatment of them has been as widely different as of any other two affections in the whole catalogue of diseases.

Briefly stated, diphtheria belongs to the contagio-infectious diseases. It is propagated by a specific disease poison, is infectious, and being inoculable belongs to the typically contagious diseases.

Such cannot be said of croup. We do not regard it as infectious, neither has it been produced in others by contact, nor in the lower animals by inoculation.

Diphtheria may be an entirely local disease, without causing constitutional disturbances, and be confined to any other locality than the air-passages. I have observed a case in which it was confined to the glans penis, occurring in a member of a family, some of whom had been affected with it in its more usual form. In this case the membrane formed, entirely covered the glans and could be removed, as a glove finger from the finger it covers. This was as genuine a case of diphtheria as when it affects the air-passages with constitutional disturbances. Who would expect to find croup in this situation?

The whole tendency in diphtheria is to adynamia, while in croup we have a sthenic reaction; what we most fear in diphtheria is blood poisoning, either from the specific poison of the disease, which I believe is a bacterium or from sepsia producing a septicemia. In croup we have no such fears, the blood poisoning we have it is true, but it is of that variety we have in a case of strangulation—by retained carbonic acid. The origin and dissemination of diphtheria are favored by filth and such conditions as favor bacterian life, such cannot be said of croup, which is more due to atmospheric conditions, such as damp and cold.

In the treatment of the two diseases we recognize those very different phases and tendencies in their clinical history. In diphtheria our aim from the very first is to prevent the blood poisoning, and if this takes place to prevent its disastrous consequences by the supportive and stimulant plan of management. When we have met these indications, we have done about all that can be accomplished by any plan of treatment. In croup, all recognize the importance of early and continuous active and almost heroic plan of treatment. There is no other disease in which I employ such active measures with so great determination. We have a high temperature, rapid pulse, that tolerates veratrum to a greater extent than any other in which I have ever used it, but by pushing it you can bring the pulse beat down and hold it, to any desired rate. Who would think of using veratrum in most cases of diphtheria? Then in croup, venesection may be practiced with benefit. Again, who would bleed in diphtheria? In croup, active emetics may be used with benefit. In fact, I may say briefly that in croup I would select my weapons to fight an active foe, viz.: the lancet, veratrum, emetics, ice bladders and lime-water spray, while in diphtheria they would be disinfectants, bacteriacides, arterial and general tonics, stimulants and supportives. Such are the lessons derived by observing the clinical history of these two diseases, and I may reiterate that the physician who heeds these lessons and directs his treatment accordingly will be best satisfied with the results of his management of the two diseases.

DR. J. R. MARSHALL, OF DUBLIN.

My views can be best presented in the form of a comparison between the two diseases :

MEMBRANOUS CROUP.	DIPHTHERIA.
1st.— Is a sthenic or acute inflammation of the mucous lining of the bronchia.	Is an asthenic or subacute inflammation of the mucous lining of the fauces, larynx, pharynx and nares.
2d.— Is ushered in with violent functional and constitutional disturbances, such as cough, fever, hoarseness, with dyspnea.	Comes stealthily, less violent, without cough or dyspnea.
3d.— Duration is comparatively short, runs a rapid course—from 5 hours to two or three days.	Duration is comparatively long, runs from 5 to 20 days.
4th.— Is not contagious or epidemic.	Is epidemic, and by many authors is considered contagious.
5th.— Is peculiar to children under 10 years of age.	Is common with all ages and sexes.
6th.— No fetor of breath.	Always a bad fetor of breath.
7th.— Breathing short, with slight expansion of chest, and livid countenance.	Breathing longer and deeper, with greater expansion of chest and less lividity.
8th.— There is no ulceration of mouth or throat.	There is often extensive ulceration which may cause septicemia and entire arrest of assimilation and nutrition, and failure of the heart's action as a consequence.
9th.— Termination in resolution (recovery), or in death by apnea.	Termination in resolution (recovery), or in death by asthenia.
10th.— Treatment: anti-phlogistic and sedative. Mercury, antimony, opium, and tobacco are serviceable.	Treatment: tonic and anti-septic: mercury, antimony, opium, and tobacco, either or all, would do great harm and complicate, and lead to fatal results.

DR. J. HELMICK, OF HARRISBURG.

Croup and diphtheria are two distinct diseases, croup being sthenic and diphtheria asthenic, in character. They require wholly different treatment. The treatment of croup is almost universally commenced by an emetic, while the treatment of diphtheria is generally sustaining from the beginning, by stimulants, such as quinine, iron, whisky, wine or brandy. In pseudo-membranous croup, the patient generally dies. In diphtheria, they almost uniformly recover. I have seen cases of pseudo-membranous croup in which there was no evidence of diphtheritic patches on the throat or tonsils, and there certainly never was a case of diphtheria that had not the diphtheritic deposit in the throat. I admit there is a family likeness between croup, diphtheria, scarlatina and typhoid fever. In diphtheria there is a fetid breath, and discharges from the nostrils, and neighboring glands are swollen. These symptoms are absent in croup. Croup is sporadic, diphtheria epidemic. It is strange that authors from all time have claimed and treated croup as a distinct disease, while now, some medical gentlemen claim they are identical. Were I called to a case of croup to-night, in a family of six children, (for we are almost always called to such cases in the night) I would not think of warning the parents against the contagiousness of the disease, simply because it is not contagious. Upon the other hand, were I called to a case of diphtheria, I should certainly warn them that it was a contagious disease, for diphtheria will attack the old as well as the young, but croup seldom attacks any but children. With such experience and evidence as this, I am clearly of the opinion that croup and diphtheria are distinct diseases.

DR. E. B. PRATT, MT. STERLING.

I believe that diphtheria in its initial stage is a local disease, the constitutional symptoms being secondary events; and while I am a firm believer in the unity of diphtheria and pseudo-membranous croup, so called, my belief being based on the fact that the grand arbiter of all pathological questions, the microscope, reveals no difference in the character of the pathological product—the membranes present in either case, still I am willing to admit the *apparently* great difference in clinical events which is so constantly urged by observers who believe in the duality of the diseases.

I am fully persuaded, however, that an adequate explanation of this *seeming* difference can be found in the greatly varied distribution of histological elements, such as elastic fibre, epithelium, lymph ducts, blood vessels, nerves, acinous glands, muciparous follicles, and submucous

tissue, in the anatomical construction of parts which in turn may become the seat of diphtheritic infection, as the nose, mouth, tonsils, epiglottis, vocal cords, larynx and trachea.

Of all the tissues just enumerated, elastic fibre is the least affected by morbid agencies, and offers the greatest resistance to deep diphtheritic infection, and is found most abundantly in the tonsils, epiglottis, vocal cords, larynx and trachea. Where pavement epithelium abounds, we find the most frequented spot for the reception and development of the poison; hence the tonsils, from their prominence and the nature of their covering, constitute one of its favorite sites. Where muciparous follicles are numerous, their secretion, as a rule, prevents deep seated degeneration of tissue, by loosening the membrane and hastening its removal; in their absence no such loosening and separation can occur, except after suppuration is established; hence if lymph ducts abound in the part affected, the systemic infection will be greater and the disease more severe. It now becomes apparent that Virchow made a mistake, some years ago, when he sent forth his dictum that diphtheritic membrane was adherent to and even incorporated with the mucous membrane, while croup membrane was situated upon and even detached from the mucous membrane. The truth is, we can often observe both conditions in the same case of diphtheria, if the poison has been deposited on both the tonsils and fauces; in the first situation the membrane will be closely adherent to the tissues beneath it, while in the latter it may be partially detached, by action of the muciparous follicles beneath it, and flapping like a curtain with each respiratory act. Muciparous follicles are more abundant in all other situations than in the tonsils and vocal cords; indeed, they are entirely absent in these two last situations.

In localities where there are no lymph ducts, there will be no blood poisoning; hence the benign character of simple tonsillar diphtheria; hence the *seemingly* sthenic character of laryngeal diphtheria—especially when confined to the vocal cords—the so called pseudo-membranous croup of the champions of the dual theory.

A few words with reference to the vocal cords:—They stand as sentinels at the narrow entrance to the lungs; they are covered by pavement epithelium, the favorite seat of the diphtheritic poison; they have no muciparous follicles or acinous glands, to effect a speedy removal of the diphtheritic mass when infection does take place, neither have they any lymph ducts by which general infection can spread. Besides, suffocation sets in too early—especially in case of children—for adjacent lymph vessels to become the bearer of infection in case the deposit should macerate. So in localities where diphtheria has died out as an epidemic occasional cases, with but little if any infecting power, will be known for years or even decades, as so-called sporadic pseudo-membranous croup, as we speak during a long lapse of years of an occasional case of sporadic cholera, or dysentery.

CANCER OF THE INTESTINAL TRACT.

Operations for the removal of Malignant Strictures of Pylorus and Intestines. Together with a brief Review of the Historical Development of Modern Abdominal Surgery: An Argument Submitted to the Cuyahoga County Medical Society, April 3d, 1883, upon the Question of the Justifiability of Operations for the Removal of Cancer of the Intestinal Tract.

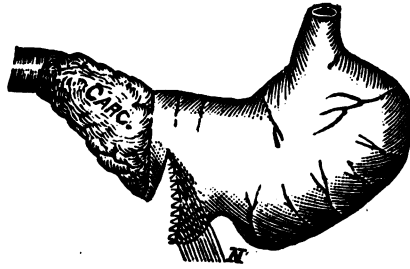
BY REUBEN A. VANCE, M. D., CLEVELAND, O.

Professor of Operative Surgery and Clinical Surgery, in the Medical Department of Wooster University, etc.

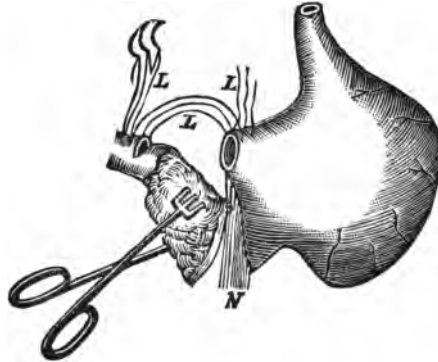
In order to discuss the justifiability of operations for the removal of cancerous tumors of the intestinal tract—the stomach and intestines—we must first ask, Why should cancers be removed at all? It would take too much time to even glance at this question, so I will take for granted the axiom in surgery that malignant growths of all forms demand immediate and complete removal. To this rule there are few exceptions, and these more apparent than real. Cancerous tumors of the brain are not operated upon for the simple reason that the organ from which the morbid mass takes its origin is too delicate a structure for the necessary manipulations of the surgeon. The same is in a measure true of cancer of the liver; here it is not the peculiar structure of the organ affected so much as it is the danger of hemorrhage that prevents the surgeon cutting away malignant growths developed in the hepatic substance. No such dangers attend upon the excision of cancerous masses from the intestinal canal—on the other hand there are cogent reasons demanding their removal. It is but infrequently that the physician or surgeon can know beforehand just what will be found in the abdomen when necessity demands that its recesses be explored, and as there are special circumstances occasionally demanding excision of malignant growths of the intestinal tract, as well as a series of real and imaginary dangers attending any operation in the abdomen, I ask the patient attention of the Society while I briefly review the Historical Development in recent years of the Surgery of the Abdomen. This necessitates a consideration of the various methods of treating penetrating wounds of the abdomen, as well as an outline of the operations resorted to for the relief or cure of surgical affections of the abdominal viscera. I know of no course, so well calculated to afford a correct idea of the real nature of surgery; none that will so well reflect the progressive improvement of surgical art, or so truly exhibit the gradual elimination of truth from error.

Vol. I.
No. 10.—2

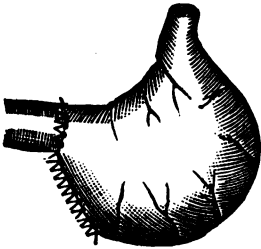
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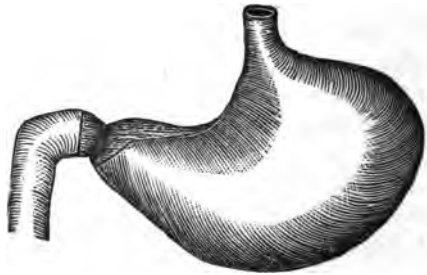
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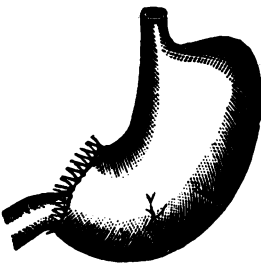
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6.



The action of that ecclesiastical council which forbade the clergy performing bloody operations drove Chierurgery from the Monasteries, and developed a class of practitioners who finally assumed power and professional consequence in the French Academy of Surgery. Our present inquiry requires us to devote a moment to the physiological views and pathological speculations of one of the eminent representatives of this Academy—the great surgeon, John L. Petit. While recognizing the fatality of abdominal wounds as the rule, this observer felt constrained to offer an explanation of the curious fact that occasionally an individual would recover from an injury of this character. It was with this object in view that Petit announced those physiological speculations that since his day have played so important a part in the surgical pathology of the abdominal viscera. Briefly stated they are as follows: The abdominal organs are maintained constantly under pressure; this pressure serves to keep the visceral and parietal layers of peritoneum in contact, and suffices in cases of penetrating wound puncturing stomach or intestines to drive any food or feces that exude into the wound and out of the body, thus obviating all danger of effusion of extravasated material into the peritoneal cavity. Furthermore, in the mutual relations of abdominal walls and contained contents, while in respiration there is a direct movement of mass, there is no change of position on the part of individual constituents of the abdominal viscera. Thus, a given portion of the intestines, for instance, always remains behind that part of the abdominal wall in the rear of which it was originally developed. Consequently a knife driven into the abdomen makes a wound in which the deep portion always remains in direct contact with the superficial opening. It is readily seen how these ideas elucidate cases of recovery from penetrating wound of the abdomen. The absence of change of relation on the part of the viscera, and the persistence under all circumstances of particular organs in contact with given areas of the abdominal walls, together with the influence of pressure between the muscular walls below and the diaphragm above explain completely these occasional cases of recovery.

Upon these speculations the Italian surgeons founded a line of practice known as Scarpa's method relating mainly to the treatment of wounded intestines that had protruded. The principle of letting alone wounded intestines that remain in place, tacitly assumed to have emanated from Petit, was carried to its logical conclusion in the practice of Scarpa in the management of wounded and protruded intestines. Assuming as correct the conditions of the abdominal viscera taught by Petit—the uniform pressure and absence of relational movement, especially—what was more

proper than the return unclosed of these wounded organs, if the opening in the gut could not deviate from the incision in the wall, and the general compression under which all these organs were maintained sufficed to eject through the wound the food or feces that chanced to approach the region of the intestinal lesion? Here, then, is a line of practice endorsed by eminent surgeons as justifiable and proper, to which a moment's attention should be given. Is it not worth our while, now that we are assembled confessedly to pass upon the justifiability of a modern surgical procedure that we devote a moment's thought to the manner in which this procedure of Scarpa became the orthodox surgical method of treating wounded and protruded intestines?

But surgery then as now was not the exclusive property of any nation or of any race; John Bell, the illustrious expounder of surgical pathology in Edinburgh, in his eloquent lectures upon wounds, reviewed in a masterly manner, these lesions of the abdomen. Accepting the doctrines of Petit, and even adding to them his own conceptions, he nevertheless rejected the practice of the Italians. Granting the truth of Petit's teachings as to the uniformity and constancy of pressure, and the absence of relative movement in the abdominal viscera, John Bell denied the presence of anything like a cavity in the peritoneum during life, and held that the adhesive process, by uniting the edges of the wound, checked the progress of inflammation and saved the patient from fatal peritonitis. Thus, the student of surgical opinion can trace the progress of certain theoretical conceptions and review the practice founded on them from France, through Italy, into Scotland. These theories of what the abdomen should be, were not based upon the revelations of Nature, but founded on the conceptions of representative teachers. We see Scarpa accepting as eternal truth the ideas of Petit, and basing on them practices involving life or death. Bell, although an advocate and exponent of theory, in practice departed from the plan of Scarpa, and introduced a method of his own—that of stitching the edges of the wounded gut to the borders of the cutaneous incision. Here we are again presented with the same problem that confronts us to-day: here is a surgical leader daring to deviate from the precepts of the time, and introduce as justifiable an operative procedure not in conformity with the theoretical conceptions of the ruling schools of the period. To see how this daring innovator was censured by the orthodox practitioners of the time one has but to glance at contemporary historical records—the surgeon who, in opposition to the ideas of Petit and the practice of Scarpa, did not return the open gut from which fecal matter was dripping into the delicate cavity of the peritoneum, was

denounced as a "cutter and slasher" by the self-constituted authorities of that day, just as to-day, similar innovators are censured by modern representatives of the same class that so persistently hounded John Bell!

But science is slow of growth, and truth is revealed only by degrees. Just as representatives of French, Italian and Scotch surgery successively grasped this question, and each contributed his mite to the Historical Development of Abdominal Surgery, so it proved in the end as regards English and American surgery. Benjamin Travers was the first inquirer who turned the rays of scientific experiment and observation on this topic, and his work is a mine of valuable truths. The fact he unfolded with which we are mainly concerned relates to the treatment of wounded and protruded intestines. He did not deny the truth of Petit's and Bell's theories—he even added the weight of his authority to the ideas they entertained of the way Nature manages and occasionally cures penetrating wounds of the abdominal viscera. He showed that as regards the application of Petit's and Bell's theories, an intestine in place and one protruded were very differently situated. Granted, says Travers in effect, that Petit's universal pressure and absence of rational movements will keep the visceral and parietal surfaces of the peritoneum together and force extravasated food or feces into the wound and out of the body—granted, with Bell, that there is practically no peritoneal cavity into which effusion can occur, and that the irritation due to the ejection along the walls of the wound of food or feces, blood or urine, causes the peritoneal edges to melt down into a glutinous mass that will make them adhere and cut off the passage of inflammation to the peritoneum—granting all this, yet no one can successfully maintain that there is any similarity between the condition of an intestine in place, and one that has been extruded. The extrusion of an intestine carries it away from the segment of abdominal wall with which normally it is in contact, and we can never make sure that in efforts to return the gut we will get it into its right place. Therefore, to return a wounded gut, with the wound open, is to place the abdominal viscera in a condition quite unlike that Nature would effect had there been no protrusion. So Travers unfolded a line of practice that has proved a permanent addition to surgical science. He stitched up the wound in the intestine before returning it. But this innovation did not pass unchallenged, and just as Bell was denounced for deviating from the method Scarpa founded on the theories of Petit, so Travers was censured for following a plan different from that introduced by Bell. May I not be permitted to suggest that in these lessons from the pages of surgical history a precedent be found for our guidance to-day; is it not bet-

ter that our practice in matters involving life or death be founded on observation and experiment rather than on theory and authority?

To those remaining undecided let me cite the next incident in this historical retrospect: one in which we are doubly interested, for it not only unfolded truth, but sprang from the brain of an American, Samuel D. Gross, then a Professor of Pathological Anatomy in this State. Gross followed the English school, by resorting to experiment; he deviated from them by daring to question the infallibility of Petit's and Bell's theories, and while adopting the practice of Travers, he rejected absolutely the methods of Scarpa and Bell. He showed that the presence or absence of effusion made the difference between life or death in the horribly fatal cases of penetrating wounds of the abdomen in which the intestine remained in place; the cases in which according to Scarpa, Bell and Travers, Nature has best calculated to deal advantageously with this lesion. The light cast on this subject by the observations and experiments of Gross placed matters in a different position. We can now see why it was Petit only formulated his ideas of the behavior of the abdominal viscera as an explanation of the rare and exceptional cases that recovered. One can now see the fearful blunder of adducing these theoretical conceptions of what the abdomen should be, as laws of Nature, and founding upon them a line of surgical practice! The innumerable pages written to unfold the views of Petit and John Bell have been set at naught by the experiments of Gross. The whole superstructure erected upon the idea that the forces of the abdomen were sufficient to prevent effusion into the peritoneal sac, has fallen to the earth. It is instructive to note that the only observations that have proved fruitful in all this history, are those based on actual experiment. The practice of Scarpa, based as it was on the theoretical conceptions of Petit, proved horribly fatal; that of Bell, founded on Nature's method of dealing with intestinal fistulæ, was a grand step towards truth; while that of Travers has not been improved upon since. Contrast this with their practice in cases where the intestines were wounded but not protruded. Notwithstanding that Petit only advanced his peculiar views as an explanation of the mechanism of recovery in the exceptional cases that escaped death, his ideas were made the foundation of Scarpa's practice, accepted and added to by Bell, and adopted even by Travers. The latter went so far as to claim that recovery from penetrating wounds of the intestines was not the exceptional event, but the general rule. To Gross we are indebted for the overthrow of these ideas, and the introduction of true views of abdominal physiology. Gross demonstrated that effusion depends largely upon the size of the

wound and the condition of the intestine. He also advocated abdominal exploration in cases of effusion. Travers improved upon the methods of Bell, and formulated our present practice in cases of wounded and protruded intestines; Gross exhibited errors in the views of Petit, Bell and Travers, and enunciated the correct rule of procedure in penetrating wounds of the abdomen attended by effusion. Have we not food here for reflection, and so on an occasion like this, assembled as we are to discuss, and it may be to pass upon, the justifiability of an operation involving the same results, situated in the same field and environed by the same fallacies as the ones just reviewed, does it not behoove us to give this matter careful thought, and before coming to a conclusion, to weigh well all the evidence bearing upon this subject, as well as dismiss from our minds all preconceptions based on mere authority?

These historical researches would not be barren were there no further facts to be deduced from them than those regarding penetrating wounds of the abdomen. French, Italian, Scotch and English surgeons were content to extol, as the perfection of treatment, a method in which Nature, unaided, did all that was done for the patient's restoration—a system that lost more than nine out of ten cases—and the myths upon which this practice was based were only exploded by the labor of a man still living. We find here the lesson so frequently taught by modern progress: that reliance upon authority, and neglect of observation and experiment are the main enemies of science. Not only that: we find operations based on error, and attended almost invariably by death, perpetuated by authority as the correct practice, while the proper method was denounced by self-constituted leaders of the profession as a reprehensible proceeding. May we not learn from this historical retrospect to be a trifle cautious in either lauding established practice, or denouncing new measures as unjustifiable?

We have now reached a point where inquiry can profitably be made as to the hesitancy of our surgical predecessors in exploring the abdominal cavity in cases of intestinal wound, or intra-peritoneal disease. Monro, of Edinburgh, many years ago, announced that the air exercised a corrosive influence upon exposed serous membranes; that penetrating wounds of the abdomen were fatal because the air thus gained access to the peritoneum. It is thought by many that we have an explanation of the speculation of Petit, and the practice of the French and Italian surgeons; the mortality of abdominal wounds was due to air reaching the peritoneum and exciting fatal inflammation—those patients that escaped were the fortunate few who were aided in the manner already detailed by Nature's

supposed conservative provisions ! Although John Bell protested against the imaginary irritating qualities of the air, the doctrine still remained fixed in the professional mind, and to-day has many advocates. Gross had to contend against it when he advocated exploration in cases of effusion, and the only doctrine that bids fair to supplant it, is the view that has gained ground since the recent extension of the surgery of the abdomen in the removal of ovarian tumors, that the great mortality of abdominal lesions is due to septic rather than inflammatory causes. It seems as if no amount of mere mechanical irritation can develop peritonitis ; that the peritoneal sac can be opened and its contents handled with impunity, provided only that the exposed surfaces are properly cleansed, and the abdominal cavity freed from extraneous organic substances. Yet, on the other hand, the slightest amount of organic matter—food, feces, blood, pus or urine—in the peritoneal cavity suffices to initiate a series of changes that result in death from blood-poisoning. It is septic substance, and no mere traumatic irritation that stimulates the peritoneum to the effusion of products that poison the patient ; remove this material, and the subsequent dangers are trivial !

It would take altogether too much time for me to follow further the progress of abdominal surgery ; to show how very slowly true views of the manner in which Nature deals with intestinal sutures gained credence ; or how gradually surgery has reached its present comparatively perfect method of treating intestinal lesions. The necessity demanding excision of foreign bodies accidentally reaching the stomach demonstrated the non-fatality of gastric wounds, the accidents attending strangulated hernia revealed the fact that large portions of the intestines could be removed and the patients still recover. The study of the morbid anatomical appearances presented by these patients in after years, together with the intestinal lesions in individuals dying of intus-susception immediately after the strangulated part was voided, cast light upon the mechanism of recovery. These facts, supplemented by experiments upon animals, show that the peritoneum can be opened, a portion of the intestinal tract—segments of either stomach, or large or small intestines—excised and by properly approximating the peritoneal edges of the wound, the continuity of the gut can be re-established. It is now more than forty years since Reybard, of Paris, took out a section of the colon in excising a cancerous mass from the large intestines. In recent years Spencer Wells has not hesitated to remove a portion of the intestines intimately attached to an ovarian tumor. Cases that have passed through my own hands convince me that in the vast majority of instances of primary cancer of the intes-

tines, excision of the diseased part is not only justifiable as a surgical procedure, but it is one of the most promising of all the measures developed by recent researches. It would indeed be singular were educated and skillful representatives of modern surgery to reject as unjustifiable, an operation that not only relieves obstruction of the bowels, and prevents immediate death, but removes the primary encroachments of a fatal malady, while yet of a local character!

Obstruction of the bowels is generally the first evidence of cancer of the intestinal tract. In those rare instances in which it is not the symptom drawing attention to the condition of the abdomen, it is one of the phenomena soon developed by malignant disease of the pylorus, small intestines, cecum, colon or rectum. The necessity of opening the abdomen and searching for, and if possible removing, the cause of the obstruction, is acknowledged by representative surgeons the world over. Mr. Bryant, of London, says: "Indeed, I believe a surgeon may as well delay in cutting the rope in a case of suicide by hanging whilst he is speculating as to the influences which have led the man to perpetrate the act, as to delay operative interference in a case of acute intestinal obstruction with the hope that he will be able to make a scientific diagnosis of the case, or that something will turn up by which relief may be obtained." Dr. Carson, of Cincinnati, claims that "it is not required of the surgeon to diagnose the *precise cause* of the obstruction *so long as the diagnosis of its existence* can be determined." To this I would add that not only is it the duty of the surgeon to explore the abdomen in all cases of intestinal obstruction, but he should open the peritoneal sac and investigate the condition of stomach and adjacent parts in tumors of the pylorus impinging upon the passage-way between stomach and duodenum. This rule would expose to view the first manifestations of malignant disease of the abdomen, and enable the surgeon by excising strictured portions of the intestinal tract to make sure of removing cancer in its incipency. I would urge this rule, not so much for its application to intestinal excisions—for there its propriety is little questioned by experienced surgeons—but with special reference to the pylorus. If the disease be limited to a slight area of stomach, and have not implicated adjacent parts, the surgeon can reasonably expect to effect a complete removal of the morbid mass, and his patient will partake of the advantages incident to early and efficient excisions of malignant growths. Not only this: there are so many cases in which a condition simulating scirrhus of the pylorus develops and causes death, in which nothing but fibroid degeneration of this part of the stomach can be proved to exist, that an early and efficient excision is of equal benefit to the patient without regard to the malignancy or non-malignancy of the tumor.

There are certain points connected with excisions of portions of the intestinal tract covered with peritoneum, common to all these operations, which demand consideration in every case. These relate mainly to extent of disease, treatment of adhesions, management of viscera during operation, and disposition of parts afterwards in manner calculated to facilitate recovery. In the first place, no procedure of this character should be undertaken save with the distinct understanding between patient and surgeon, friends and assistants, that the operation is primarily of an exploratory character, and made, first of all, for the purpose of revealing the true nature of obstruction of the bowels, or obscure lesions of the abdominal viscera. This leaves the surgeon free to act according to the dictates of his best judgment when the site of disease is revealed and its true character exposed.

Rokitansky has shown by the unanswerable evidence of morbid anatomy, the rarity with which cancer extends from pylorus to duodenum. The researches of Gussenbauer and Winiwarter prove that the pylorus is by far the most frequent site of primary cancer of the stomach, and their statistics reveal that neighboring organs are implicated at a comparatively late stage of the disease. It has also been demonstrated that cancer at any part of the intestinal tract may develop, and produce obstruction of the bowels without adhesions occurring. It very rarely happens that adhesions are found in any stage of the affection which would prove an obstruction to the surgeon's design. If they do exist the surgeon can compress them with an instrument like Liston's bone forceps, and after thus crushing them, can sever them without the least danger of hemorrhage. The original incision in the abdominal wall should be so situated as to expose thoroughly the area of disease. Should the surgeon ultimately determine to cut out the cancerous mass he should primarily take such precautions as will render the opening of the peritoneum harmless. While dismissing the dogma of Monro as to the corrosive quality of the external air, and sending with it, as exploded doctrines, the speculations of Bell and Travers, it by no means follows that peritoneal wounds are as free from danger as incisions of the limbs. The peritoneum has an enormous surface, constantly moist, and one, which, when exposed, leads to such rapid cooling of the blood, that immediately reflex paralytic contractions of the heart, and even death, are threatened. Nussbaum points out another source of danger in the almost unlimited power of absorption which the peritoneum possesses; thus, any exudation which has undergone unhealthy metamorphosis may poison the blood. Peristaltic action, by which any exudation in the peritoneal sac is stirred up and spread over the whole peritoneal surfaces, and the respiratory movements, combine

together to facilitate freedom of absorption. Again, peritoneal wounds are dangerous on account of the innumerable little spaces existing everywhere, into which secretions find their way, lie hidden and decompose. Finally, there is the deleterious influence of the ill-smelling intestinal gases which especially favor sepsis; gases which find their way in and out even when the bowel itself is in a healthy state. Since these dangers have been understood and the means by which they may be overcome have been learned, the judicious surgeon is enabled to obviate them.

Every possible precaution should be taken to guard against infection; the spray must therefore be used. The incision in the exploratory operation should be made in the middle line, and if possible over the tumor. Should the tumor extend to one side, a lateral incision can be made at right angles to the original opening when excision of the pylorus has been determined upon. If other viscera are involved—especially the liver, pancreas or descending duodenum—or the disease extend over the greater part of the stomach, the wound must be closed and the patient abandoned to his fate. When there are few if any adhesions, the disease limited to a circumscribed region of the pylorus, and the patient in good general condition, the case is one favorable for excision. The operation is not contra-indicated even in combined gastric and intestinal cancer, provided the latter is limited to an accessible part. A patient in whom the pylorus is alone affected can be operated upon in this way: The tumor exposed and its extent and character determined, it is drawn as far as possible into the wound and the line of incision determined upon. This depends upon the size of the mass, and the region of stomach impinged upon. In the first illustration it will be seen that the symmetry of the stomach depends largely upon the procedure adopted. The first and second figures show that a very unsightly angle may be made at the terminal portion of greater curvature unless the primary incision be directed as denoted in figure three. Figures four and five exhibit certain advantages that attend upon the attachment of the duodenum to the greater curvature of the stomach. The line of incisions decided upon—and this necessitates a conclusion as to the place of insertion of intestine into stomach—the next step is the isolation of the tumor. To do this pylorus and adjoining portions of stomach and duodenum must be freed from adjacent parts. Unless the surgeon is supplied with the requisite appliances, he will find this the most difficult part of the whole operation. With an instrument like Liston's bone forceps, the omentum can be severed, blood vessels compressed and hemorrhage prevented. Any blood vessel that the surgeon hesitates to leave without additional security can be tied with a double ligature and severed between. In some cases the omentum has been re-

moved without any tendency to hemorrhage. The greater curvature is isolated, the lesser curvature is freed, the tumor separated from omental attachments and all enlarged glands extracted. The stomach can now be drawn through the wound and in great part out of the abdominal cavity: a large, soft sponge, just wrung out of hot water, is placed under the tumor, and the subsequent proceedings are extra-peritoneal. These relate to, the excision of the diseased mass. A glance at the accompanying illustration will show how important it is to have the line of incision properly directed through the stomach in order that the organ may preserve its symmetry after the tumor is extracted. If the duodenum is to be attached to the stomach near the lesser curvature, as shown in figure three, the procedure illustrated in figure one and two can be adopted. The surgeon makes a slight opening in the anterior wall of the stomach on the line of incision, and through this opening a glass tube is inserted. This is connected with a reservoir of water by elastic tubing, and the cavity of the stomach is alternately distended and emptied of water until the fluid returns clear; the surgeon then proceeds with his incisions. Scissors are used, and after each cut, the hemorrhage is checked. In checking hemorrhage from vascular membranes I know of no device equal to a back stitch made with a small, well waxed thread, mounted on a slender needle, the whole bleeding surface being guarded by a line of stitches passing through mucous and muscular coats about one-eighth of an inch from the border of the wound. In this method each loop includes one-half of its predecessor, and is encroached upon by one-half its successor, and thus, by drawing the threads tight, all danger of hemorrhage is effectually avoided. As the incision is carried forward, hemorrhage is checked in the manner provided for above, and steps are taken to close the opening in the stomach in excess of the aperture required for the insertion of the duodenum. This is accomplished by passing sutures after the method of Lembert—through the serous membrane alone, entering at a half inch from the incision and emerging one-eighth of an inch from its edge, crossing the incision, entering the serous membrane one-eighth of an inch from the edge of the wound and emerging a half inch from it; a suture that accurately approximates the serous borders, but one which in this operation needs to be supplemented by firm stitches through the mucous membrane internally. In figure two the progress of the surgeon's manipulations can be traced to the point where the Lembert sutures to unite upper and posterior borders of the gastric opening with like borders of the wound in the duodenum have been inserted. The ends of the sutures in the lower part of the stomach were left long in order to afford a convenient method of handling the organ. The hemorrhage following incisions

in the duodenum is to be checked by back stitching, just as in the stomach; during this time the tumor grasped with forceps in the hands of an assistant, has served to hold the duodenum in place. Hemorrhage checked, the cut surfaces of the duodenum are united with corresponding borders of the stomach, and the edges of the mucous membrane are stitched together. This process is continued until the tumor is free, the hemorrhage controlled, the Lembert sutures inserted and tied, and the borders of the mucous membrane sewed together over all but the last fourth of the opening; here, the necessities of the case demand different measures. Heretofore all the stitches and threads were fastened so that they could in time be discharged into the cavity of the intestine; it is essential now to employ a few interrupted sutures that in the nature of things cannot be so favorably placed. Lembert sutures are inserted, the serous borders of the opening at the junction of duodenum and stomach are everted, and the sutures tied; this closes the aperture, but does not make the union sufficiently firm—interrupted sutures going through all the coats are inserted between the Lembert sutures, tied, and cut short; this remedies the defect. It also completes the operation so far as removal of tumor and re-establishing communication between stomach and duodenum are concerned. Figure three gives an idea of the appearance of the stomach; figures four and five show deviations demanded when the union between stomach and duodenum is effected at the greater curvature. Figure six exhibits the manner in which Lembert's suture approximates peritoneal surfaces in this operation; it also illustrates the manner in which the mucous surfaces are united over the attached serous borders of the wound. This illustration while showing the apposition of serous borders brought about by the Lembert suture does not exhibit the true site of the knot in the stitch passing through the peritoneal tissues. This knot varies with the side from which the suture is inserted. In the true Lembert suture the thread is not only introduced from the serous surface, but it returns through it. Yet the sixth illustration reveals the manner in which these tissues are approximated when necessity demands these stitches be inserted from the inner surface of the viscera. Take the condition of affairs revealed in figure two, and instead of inserting the Lembert sutures shown loosely extending from duodenum to stomach, remove the tumor, approximate the edges to be united, and insert the needle from within, through muscular and serous coats of stomach, into the serous and muscular walls of duodenum, then draw the suture tight and tie. This will place the knot in the position shown in figure six; by subsequently uniting the mucous surfaces with interrupted sutures the precise condition there shown will be produced. The long ends of the sutures,

left so in order to afford a firm grasp of the organs operated upon, can now be severed, the abdominal cavity cleansed and the external wound closed.

When we consider the circumstances under which this operation has heretofore been performed—the exhaustion of the patient and the constitutional implication—the only wonder is that they survived. Reverse this state of affairs, operate early, excise the tumor while yet local, before the constitution is broken down and the patient on the verge of death from exhaustion, and at once the surgical aspect of this procedure is revolutionized. This will place patients with cancer of the pylorus on the same plane with those suffering from malignant diseases of the intestine; those with simple fibroid degeneration of the terminal orifice of the stomach on a par with those having a benign stricture of the gut. In both cases the surgical principle involved is simple; it is to excision, and excision alone, that the patient can look for relief, and the man who fails to afford such a sufferer the relief he seeks, and give him the benefit of the chances left him, is unworthy the name of surgeon.

The shock of the operation soon passes off, and although one can conceive of dangers incident to rupture of sutures by excessive gaseous distension, and collapse from extravasation, still such consequences are rarely encountered. Again, although hemorrhage is possible, septic conditions, due to peritoneal effusion, are the real danger. This is indicated by changes in pulse and temperature, and is attended by the presence of an acrid fluid in the peritoneum. The practical fact is that the advent of phenomena indicating septic conditions should at once lead to exploration of the abdomen, and, if necessary, cleansing of the peritoneal sac.

In bringing this statement to a close, permit me to again urge the importance of deciding questions of operative procedure upon Surgical Principles, and not upon the fears, the preconceptions, or the prejudices of any man or any set of men. As the excision of malignant growths of the intestinal tract involves the local or constitutional nature of cancer, the mechanism of repair in intestinal lesions, and the safety of all abdominal operations, let the appeal be made to the solution which Modern Surgery gives these important problems. Judged in this way there can be but one decision, and that to the effect that these operations are justified by all the Precepts and Experiences of Modern Scientific Surgery!

SURGERY.

DIAGNOSIS OF LUPUS.—By Dr. McCall Anderson, in *Medical Times and Gazette* :

Lupus Vulgaris.

1. Commences usually before the age of twenty-five, and often much earlier in life.
2. An indolent, painless affection.
3. Edges of patches, though often round and elevated, are soft.
4. Ulcers in most cases superficial, soft, throwing out profuse granulations, and edges often undermined.
5. The nose is the part of the face oftenest attacked.

Lupus Vulgaris.

1. Commences early in life, generally before twenty-five.
2. Often a history of hereditary tendency to strumous affections.
3. Oftenest met with on the face.
4. Ulceration has tendency to throw out profuse granulations, and edges often undermined.
5. Color of eruption yellowish red or violet.
6. Often of many years' duration.
7. Cured by the use of caustics and anti-strumous remedies.
8. Often other manifestations of the strumous diathesis.

Epithelioma.

1. Occurs usually in persons getting up in years.
2. Tingling, and pain often lacerating in character, common.
3. Edges hard, everted, and often having a glistening, translucent appearance.
4. Ulcers oftener deep, hard, with uneven, finely granular appearance, and exuding a sticky fluid, which gives a varnished appearance to the surface.
5. The nose is not more frequently involved than other parts of the face.

Late Manifestations of Syphilis.

1. Appears usually after the age of twenty-five.
2. History of syphilis having been acquired.
3. On any part of the body, though often upon the face.
4. Ulceration as if cut out with a punch, and base ash-gray.
5. Color of eruption in the chronic stage usually coppery.
6. Chronic, though not nearly so much so.
7. Cured by mercury or iodine.
8. Generally other manifestations of syphilis.

—*Louisville Med. News.*

A NEW TREATMENT FOR GONORRHEA.—A correspondent writes to the *Lancet* concerning what he considers a rational treatment of this common affection. He gives regularly five-grain doses of iodide of potassium, and full doses of cubebs in powder, every three hours. The cubebs in drachm doses he finds rarely fails to cut off the ailment rapidly, and the iodide, besides its solvent influence on the essential element of the powder, has a well recognized action on the various mucous surfaces.

Vol. I.
No. 12.—4

A NOVEL AGENT IN THE RADICAL CURE OF HYDROCELE.—J. E. W. Walker, M. R. C. S. E., writes: "In bringing this matter before the profession, I feel bound to admit that, but for a curious accidental circumstance, the agent might never have presented itself to my notice. In the year 1875, I proposed to operate upon a patient, aged 65, for the radical cure of hydrocele of the tunica vaginalis. The disease had existed for about ten years, and had been repeatedly emptied by other surgeons. At this time I removed, by the trocar and canula, about twelve ounces of serum, and, by accident, took from my pocket a bottle containing about two drachms of liquor ergotæ (Battey) in the place of the same quantity of tincture of iodine, which it was my intention to throw into the cavity. On my return home, I discovered the mistake, and watched the patient for some hours at intervals. No inflammatory state occurred, and there was entire absence of pain, so that I allowed my patient to return to his ordinary occupation the next morning. To the present time there has been no return of the abnormal secretion. I have since, on two occasions, used the same plan with perfect success, and I attribute the cure to a specific action, exerted by ergot, which re-establishes the balance between secretion and absorption."—*British Medical Journal*.

URINARY ABSCESS in certain strictures of the urethra may be a fortunate occurrence, provided the urethra itself is not opened and extravasation of urine so caused. But if it discharges externally in the perineum, forming a channel for the escape of the water, instead of being a cause of apprehension, it may be regarded as a happy escape from a serious condition. Reginol Harrison, speaking of the danger of extravasation, says (*London Lancet*): When, however, it is anticipated, or dealt with before much damage has been done, the risk is comparatively slight, provided the patient's health has not been seriously deteriorated by long-standing suffering. He says further, that it may occur without the presence of stricture; that gonorrhea, the use of bogies or strong injections, may produce it. Its premonitory symptoms are tenderness in the perineum, swelling, and irritation of the bladder. If there be no stricture, there need not be much anxiety, as the inflammation will generally yield to appropriate treatment. If the swelling should increase to such an extent as to press upon the urethra and cause retention, an incision will be necessary to relieve that condition, but in making it care should be taken to avoid injuring the urethra. If a stricture be present, however, and an abscess forms which opens the urethra and causes extravasation, incisions

should be made wherever the infiltration exists. It is a generally accepted doctrine that in these cases the damage is in front of the triangular ligament, and yet it cannot always be determined whether there is not also some trouble behind it. In all of these cases he not only incises the perineum, abscess and urethra, but also introduces a tube similar to a lithotomy tube, which is retained in the bladder and a means thus provided for the free escape of the urine. The tube is allowed to remain in for about a week, or until all sloughs have passed and the wound in the perineum has cleaned. In some cases he has found that the stricture, which was formerly tight and unyielding, has been so changed that it could be dilated with bougies. He says that the incision in the perineum should be in the median line; that although the abscess may be lateral, still the incision must correspond with the raphe, otherwise hemorrhage and permanent fistulæ may result. From his observations he concludes that in all cases of perineal abscess, with organic stricture and extravasation of urine, perineal urethrotomy behind the stricture should be performed, and a tube inserted into the bladder to keep it drained; that the stricture should not be treated until relief from the abscess, retention and extravasation is obtained.—*Weekly Medical Review*.

OTITIS MEDIA PURULENTA.—Prof. D. S. Reynolds, Louisville, Ky., thus summarizes a recent clinical lecture :

Unable to go more fully into the subject, I feel that, from the cases before you, two important points as to local treatment, or rather as to the action of the local agents, should be mentioned more particularly. First, there is in such cases the necessity for an agent which has the power to dissolve the fibrinous matters upon the surface of the inflamed mucous membrane, and immediately following this, an agent which has gently stimulating, astringent and antiseptic powers. The first agent, as you have seen, is found in the chloride of sodium, the second in listerine. Listerine is something more than a mere antiseptic, which its inventor, Mr. Lambert, has very extensively advertised as its chief virtue. It is a stimulating, balsamic astringent. It contains boracic acid, the essential oil of eucalyptus globulus, thymol, and some other less important ingredients. It mixes freely with water, and may be used as a local application to all purulently inflamed surfaces, diluted to any extent desirable, or as in the cases before you, in full strength. With chloride of sodium and listerine, you have, therefore, but little to desire in the way of local applications in otitis media purulenta.—*Phila. Med. and Surg. Reporter*.

AN IMPROVED METHOD OF CIRCUMCISION FOR CONGENITAL PHIMOSIS.

—Dr. Neil Macleod recently operated on a child of two years in whom the orifice of the prepuce scarcely admitted the point of a probe, but by dilating this orifice forcibly with “sinus forceps,” and the addition of a few tiny snips with scissors round the margin of the orifice thus dilated, the foreskin could be drawn back until the point of the glans showed itself. Further retraction was prevented by the adhesions referred to, but these were easily broken down by means of a probe passed between the prepuce and the glans, and this done until the corona glandis was exposed in its whole extent. The prepuce was next replaced forwards, and the amount to be cut off was marked by a clip arrangement made by tying two ordinary directors, groove to groove, at one end and slipping the prepuce into the clip formed by the untied ends. Three carbolized silk threads were then passed through the prepuce at equal intervals close to the clip on its proximal side, the glans being guarded as the needle was passed, and each thread being of sufficient length to form *two* sutures. The prepuce in front of the clip was then cut close off, the clip separated, the penis released, vessels twisted, the threads fished up with a blunt hook from the now enlarged preputial slit, cut and then tied on each side. The orifice in the inner or mucous layer of the prepuce can then be slit with scissors down to the corona, but this is unnecessary if the clip is put on so that the line of section runs in the direction from the corona to the orifice of the urethra.

The surface of the glans being annointed with vaseline, a plug of absorbent cotton dipped in one to twenty solution of boroglyceride made an excellent dressing, and was kept applied by a bandage passed round the abdomen, knotted behind, and the two ends brought forward between the legs over a piece of light macintosh or oiled silk, the bandage ends diverging so as to include the genitals, then converging and being looped through the bandage crossing the abdomen. The absorbent pad was changed every time that urine was passed. Healing took place by first intention, and not a trace of odor was detected from first to last. Carbolized catgut sutures would have been better than silk, as they do not need to be removed.—*Edinburgh Med. Journal.*—*Med. News.*

USELESSNESS OF STYPTICS IN SURGERY.—In the *Philadelphia Medical Times*, of January 27th, Dr. Roberts contributes a short but extremely common-sense article on this subject. He enumerates three objections in particular against their use:

1. “Their reputation as hemostatic agents leads practitioners to resort

to them when more trustworthy methods are needed. Thus valuable time is lost, for, after temporary arrest, the hemorrhage recurs in the already anemic patient, and is perhaps followed by disastrous results."

2. "If they fail to control the bleeding—which they generally do if the hemorrhage is important—it is often so difficult to rid the surface of the pasty clots that subsequent ligation of the vessels is well-nigh impracticable."

3. "Many styptics prevent union by first intention, because they irritate the raw surface, lead to inflammation, or induce suppuration."

These objections are tenable as a rule, but like most others they are not universal. Monsel's salt, for instance, which Dr. Roberts considers the most objectionable of all, we have seen render good service; albeit we confess to having seen it do harm many times, in the manner indicated by Dr. Roberts. Given a case of epistaxis, a Bellocq's sound, a sponge, and some Monsel's solution, and harm is very likely to result. On the other hand, given some of the same solution, a good hand atomizer, and the result will probably be very satisfactory.

Like Dr. Roberts, we believe that where torsion and ligation are impracticable, pressure is more effectual than styptics, and, in our experience, is followed by better results.—*N. O. Med. Jour.*

THE TREATMENT OF INTUSSUSCEPTION.—A prolonged and practical discussion on this subject was had at a recent meeting of the London Clinical Society.—*British Med. Jour.*

The whole field of treatment was thoroughly gone over, and the points that should especially claim our attention throughout the course of such cases were brought out clearly and distinctly. There was a pleasant unanimity of opinion, more particularly as regarded surgical interference.

The general consensus of opinion pointed to the early treatment of all cases by inflation and operation. But it was also shown that a great distinction must be drawn between cases of simple intussusception, which may last for weeks when the bowel is not strangulated, and those of strangulated intussusception, in which any delay in operating is to be deprecated, since peritonitis is almost certain soon to ensue. The former cases are those most likely to be benefited by inflation and injection of liquid per anum, possibly the two combined, while the patient's abdomen is kept relaxed by the use of an anesthetic. But if the strangulation has lasted for some time, and the symptoms are severe, so that there is reason to fear that adhesions may have formed, or the wall of the bowel have be-

come softened by the inflammatory process, inflation or forcible enemata should scarcely then be attempted. Should the case be one of severity, and inflation be found valueless, the surgeon should at once have recourse to abdominal section; just as in hernia, when taxis has failed, he directly proceeds to herniotomy.

The median line of the abdomen is to be chosen for incision. The invaginated bowel may be either withdrawn by gentle traction from the encircling portion, or its withdrawal assisted by pushing up from below. Many speakers remarked upon the extreme difficulty they had sometimes experienced in returning the distended bowels into the peritoneal cavity after the operation, a difficulty which may be necessary to overcome by puncture of the intestine with a trocar and canula, for the withdrawal of gas and liquid. But in cases in which the intussuscepted bowel cannot be withdrawn, what is to be done? As Dr. Buzzard pointed out, the portion of intestine inclosed goes on to slough and separation, and this is nature's method of cure in the very few cases which struggle on to recovery. Surgeons recommended that nature's method should be imitated, as nearly as may be, by a bold excision of all the implicated portion of bowel, and a stitching together of the two cut ends. Mr. Howse has already done this in two cases, though as yet without success. To avoid risk of the passage of any fecal material into the peritoneal cavity, he recommended that a thin sheet of gutta-percha material, with a slit in its centre, should be spread before the abdomen, and all the bowel to be operated upon drawn forward through the slit. It might then be treated without fear of fecal contamination of the peritoneum. It remains to be seen whether this bold procedure of excision will in future result in more success than has hitherto attended it. In certain cases, in which the bowel protrudes through the anus, Mr. Howse would also remove it bodily from that situation by amputation, securing the cut ends by pins. An Italian surgeon has already done this by inadvertence, not knowing what he was taking away, and the patient recovered.—*Med. Record.*

PROGNOSIS AND TREATMENT OF OTORRHEA.—The *Am. Jour. Med. Sci.*, January, 1882, says that Dr. Shiffers, of Liege, has recently written a monograph on this subject, which contains some truths which should be placed before the eyes of physicians from time to time. That singular error, that the suppression of an otorrhea is attended with danger, viz., that by stopping it there may ensue consecutive cerebral diseases, is still believed and acted upon by a number of physicians. The author of this brochure endeavors to show by irrefutable facts, based on anatomical

and clinical observation, that physicians holding such views are guilty of either culpable ignorance or indifference, and to them he addresses himself.

The author then reports a case observed by him in which a chronic purulent catarrh of two years' duration had been treated by nothing but warm water syringing. This had induced the growth of granulations and polypi in the ear, which interfered with examination of the fundus, and also suppuration of the mastoid cells. A deep incision behind the ear was followed by an escape of pus from the wound, and recovery ensued.

The prognosis in chronic otorrhea necessarily varies with the nature of the disease, of which it is only a symptom. In any case this disease demands attention, because of the intimate relation between the middle ear and organs of capital importance, such as the brain, the carotids, and the jugulars, to which the inflammation may spread. In addition to these local lesions, others of grave import may ensue, since chronic purulent catarrh of the middle ear may assume the nature of an osseous abscess, and become the determining cause of a pulmonary or a general tuberculosis. Von Troeltch is quoted as having said that subjects afflicted with chronic otorrhea never attain old age, and several English insurance companies decline to insure those with this disease.

In treating these cases, reliance must not be placed entirely on local or on general treatment. The latter should be a combination of medical and hygienic treatment. To bitter tonics and ferruginous preparations there should be joined an extended hygienic and hydropathic treatment, which latter in some instances has excellent effects. The local treatment set forth in this brochure consists chiefly in the use of the syringe and instillations, the latter being those best known—no new forms being suggested. The insufflation of powders is limited to those cases in which the discharge is slight, and the opening in the membrana tympani large.—*Amer. Jour. of Otol.*

INJECTION of a nevus with perchloride of iron produced immediately fatal results in a surgical clinic at Chicago, recently.

LYCOPODIUM can be put to an excellent use when sprinkled over oiled silk. It prevents the fabric from adhering together.

OBSTETRICS.

NEW OVARIAN TROCAR.—Dr. Jos. H. Warren, of Boston, describes a new trocar, devised by himself, in the *Va. Med. Mo.* of December, '82. Its novel features are, 1, a revolving point—the cutting edges being opposite and spiral; 2, a detachable handle—the detachment being effected as the rod is withdrawn by a mechanism similar to that in a pile driver; 3, packing just back of the point, by means of which as the point is drawn back the fluid is started, and which, as the rod is detached, prevents the fluid passing through the tube, causing it to flow out through an opening at the side specially provided for that purpose. The improvement is novel and ingenious.

ASAFETIDA IN THE TREATMENT OF ABORTION.—In the *Journal de Medecine de Paris* of December 16, 1882, are collected the results obtained by several observers in the prevention of abortion and premature labor by asafetida. Dr. Laferla, acting upon the theory that the death of the fetus was owing to an asthenic condition of the uterus, administered the drug in a number of instances. In nearly ninety per cent. of the cases so treated, the patients (who had aborted from two to five times in former pregnancies) went on to full term. Drs. Giordano and Carxani announce equally favorable results, though the number of their cases was smaller. The latter prescribes the drug in pill form in doses of one and a half grain twice a day, gradually increased to twelve grains per diem. Dr. Gourgnès recommends the administration of asafetida, in emulsion with the yolk of an egg, by the rectum.—*Med. Record.*

CAUTERIZATION OF THE CLITORIS IN THE TREATMENT OF HYSTERIA.—Dr. N. Friedreich (*Virchow's Archiv*) believes, with Baker Brown, that many cases of hysteria are caused by masturbation. Further, he is of opinion that in neuropathic females an over-sensitiveness of the sexual organs may exist, which acts upon the spinal and cerebral centres, causing hysterical symptoms, without there being actual, voluntary masturbation. He treats these cases by cauterizing the clitoris. The operation is most painful, but the results are so remarkable and agreeable that the patients, says Dr. F., never object to a repetition. Eight cases are reported, and all were ultimately cured. In two cases there were relapses, and the cauterization was repeated. In three other cases the cauterization

had to be repeated. The disease was in all instances very marked, there being paralysees, general convulsions, hystero-epilepsy, etc.—*Journal of Nervous and Mental Disease*.

TAIT'S OVARIOTOMIES.—Mr. Lawson Tait (*British Medical Journal*, February 17, 1883,) has recently published an account of two hundred and eight consecutive cases of abdominal section, performed between Nov. 1st, 1881, and Dec. 31st, 1882.

This paper, reflecting the experience of one of the boldest and most successful of modern operators, is a most valuable contribution to abdominal surgery. The importance of the subject, as well as the radical departure from the orthodox treatment will abundantly justify the following lengthy quotation :

The group of cases of which I should like to speak somewhat in detail, are those in which I have performed abdominal section on account of peritonitis, have cleared out the abdomen and drained it for a time. In the present series there are only four classed under this head, but there really ought to be nine, as that is the number upon which I operated on account of peritonitis; but finding a cause for the disease after I had got inside, the others are classed under the pyosalpinx (2), parovarian cyst (2), and pelvic abscess (1).

This illustrates again how difficult it is to make a perfectly satisfactory classification of these cases. I opened the abdomen of a lady on account of acute peritonitis, and found its cause to be acute suppuration of the Fallopian tubes. She recovered completely, and is now in perfect health. On the 7th of November last, Dr. Pike, of Malvern, telegraphed for me to go over and make an exploratory incision in a patient under his care. When I got there, I found that the patient, a young lady, of 20, under the joint care of Dr. Wadhams and Dr. Pike, had symptoms of intestinal obstruction, with undoubted peritonitis. Dr. Pike had a suspicion, which he expressed before the operation, that it really was a case of acute peritonitis, from some trouble with the right Fallopian tube, symptoms of that having been in existence for two years, ever since the patient had been chilled whilst skating. Dr. Pike's diagnosis proved quite correct, I removed a large quantity of purulent fluid from the abdomen, and I found the contents of the pelvis all glued together with purulent lymph. There was no obstruction of the intestines, but the right Fallopian tube contained pus, and had burst. I removed it, drained the peritoneal cavity, and she

recovered perfectly. Now the abdomen and pelvis are perfectly healthy, but within the last three weeks she has begun to suffer from some mysterious symptoms of which we cannot make any satisfactory explanation, save that they are probably spinal.

In the last account of my practice, which I published in the *Medical Times & Gazette* about a year since, I spoke of inflammation, as follows: "So satisfied have I been with results in these cases, that the next case of peritonitis, to which I am called, of whatever sort it be—even puerperal—I shall advise and perform, if allowed, abdominal section, shall cleanse out the cavity and drain it, and if the operation be not deferred till the patients are moribund, I believe this treatment will prove eminently successful.

"Our views of peritonitis will, I am certain, soon undergo an immense alteration. The terms 'septicemia' and 'septic peritonitis,' for which Mr. Spencer Wells is mainly responsible, and which have appeared in the mortality column as the explanation of the deaths after ovariectomy, are simple nonsense, and have led us astray altogether. In future we shall treat the peritoneum on the same principles as we treat other suppurating cavities, and with quite as secure results."

I have nothing to alter in these sentences. The success of drainage in scanning many of the cases which formerly died, proves that if we remove from the peritoneal cavity material which is over and above its absorptive power, or if we remove, in a similar way, its own effusion under circumstances when its absorptive power is temporarily in abeyance and threatening, with the life of the patient, to be permanently destroyed, we can put a stop to all the trouble. It seems to me that, whilst there are cases of peritonitis which are really septic, that is, when some kind of poison gets into the peritoneum and speedily affects the whole system, just as the bite of the cobra does, they are in the minority, and that the great bulk of cases are not of this character at all, but are purely local, and that if we can help the peritoneum temporarily by drainage we can secure a triumph. In the cases of chronic peritonitis, this is constantly the case. One of these from my last series will suffice to illustrate my success:

E. T., aged 18, was sent to me in April last by Dr. Justin McCarthy, of St. George's Shopshire, who kindly gave me the following details of her history. She had been for some time under the care of an irregular practitioner, and came under Dr. McCarty's care in a state of the greatest emaciation. Seldom had he seen any one more emaciated, unless in the last stage of phthisis, the skin drawn tightly, as it were, over the cheek

bones, and the bony prominences visible under the skin. The abdomen was enlarged, the temperature about 102° , and the pulse about 120. The chief symptoms were vomiting and diarrhea. When she came under my care, I found her quite as Dr. McCarthy described, and the presence of a large quantity of fluid in the peritoneum was apparent. I opened the abdomen on April 17th, and removed about three pints of purulent fluid and a quantity of white flocculent clots. I emptied and cleansed the cavity as well as I could and fastened in a drainage-tube. The tube remained in about a week, and during that time a large quantity of purulent fluid and small pieces of purulent lymph were discharged. When the stitches were removed the wound opened completely and several large masses of this white purulent clot were extracted, one of them being as large as a normal human kidney. The wound healed in June and about September she had completely recovered her health. I saw her on October 31st, a stout robust young woman, whom I never would have recognized as the girl who came to me six months before. This is the kind of operation which would have been regarded as madness about five years ago, but I think its success is enough to justify my rule concerning all these cases. "When the doctor is in doubt, and the patient in danger, make an exploratory incision and deal with what you find as best you can." I have not yet had such an opportunity as for a long time I have much desired in trying the operation in puerperal peritonitis. There is not so much hope in this field for its success, as I think there can be little doubt that the majority of these are purely septic. But as very few of them escape I think it would be worth trial; and I wish some of my brethren who are unfortunate to see these cases would give me an opportunity of trying it. The only difficulty is that it is like tracheotomy in croup, it must be done before it is too late, and perhaps it may be done unnecessarily. This, however, is an argument against a great deal of our practice, both surgical and medical.

AN ACCOUNT OF TWO HUNDRED AND EIGHT CONSECUTIVE CASES OF ABDOMINAL SECTION PERFORMED BETWEEN MARCH 1ST, AND DECEMBER 31ST, 1881.—Mr. Lawson Tait, F.R.C.S., Eng., Surgeon to the Birmingham and Midland Hospital for women, in a paper bearing this title, gives the following analysis of the series:—Exploratory Incision, 13 cases, with no deaths; Incomplete Operations, 8 cases with four deaths. Operation for Cystoma: One Ovary, 36 cases; Both Ovaries, 28; Parovarian Cysts, 12; Hydrosalpinx, 16; Pyosalpinx 20; or 112 cases, 3 deaths. Re-

moval of Uterine Appendages : for Myoma, 26 cases ; for Chronic Ovaritis, 12 ; for Menstrual Epilepsy, 1 ; or 39 cases, 5 deaths. Hepatotomy for Hydatids, 2 cases ; Hydatids of Peritoneum, 2 ; Cholecystotomy for Gallstone, 2 ; Radical of Hernia 1 ; Nephrotomy for Hydatids, 1 ; Nephrectomy, 1 ; Intestinal Obstruction, 1 ; Solid Tumors of Ovary, 3 ; Hysterectomy for Myoma, 10 ; Cysts of unknown origin, 1 ; Tumors of Omentum, 1 ; Pelvic Abscess opened and drained, 7 ; Chronic Peritonitis, 4 ; or 35 cases, 4 deaths. Total, 208 cases, with 16 deaths. These operations were not performed under carbolic spray.—*British Medical Journal*.

THE FLOODING OF ABORTION.—This is treated by Dr. Griswold (*Incub. Prac.*) by the introduction of a rounded piece of alum, which he calls an "egg," and always carries with him. It is of the size of a large hen's egg, oval in shape, without sharp points, but generally a little ragged. A bit of strong but not large twine is tied in a groove cut around the middle of the egg, leaving the ends so they will hang out of the vagina. Separating the labia with the first two fingers of one hand, with the other hand the egg is introduced endways, turned half round, so as to bring the long diameter across the vagina, and pushed downward and then upward against the os. If the canal is large and open, the egg can be backed with sufficient packing to hold it in position ; but in the majority of cases the supplementary support will not be needed.

This method of treatment is easy of use, speedy in operation, and effectual against further hemorrhage. The blood escaping from the uterus is very soon clotted, and an effectual tampon, extending well into the os, quickly formed. The size of the tampon is increased by the same process of clotting of any further blood coming against it. The vagina is also filled by the same process. This treatment has never failed me ; and after its use, I leave the patient with the feeling that she is safe for the next twelve or fifteen hours, so far as any danger from another attack of bleeding is concerned. No unfavorable effects have followed the use of the alum in this way in any of the scores of cases in which it has been employed ; no fevers, no septicemia, no deaths ; nothing untoward ; and I have never had occasion to use it the second time in any one case. The alum is a better antiseptic than any amount of carbolic acid that can be used ; and for this, and its powerful astringent quality, has an excellent after-effect upon both uterus and vagina. Another thing in its favor, as thus employed, over any system of vaginal packing with cloths or cotton, is, that micturition is not interfered with, as it sometimes is by stuffing the vaginal canal, and thus making pressure on the urethra. The alum can be removed when desired, either by traction on the cord or by the introduction of the fingers ; the coagulated blood fished out, the vagina syringed, and the case further treated as circumstances may require.

MEDICINE.

DELIRIUM TREMENS.—Some one has said that delirium tremens is a disease which so far as its symptomatology is concerned stands upon a tripod, to-wit: sleeplessness, delirium, tremor. I would ask you to make it a four-legged stool, and add the fact, one of the most important of all in differential diagnosis, that there is no fever. Sleeplessness, delirium, tremor, apyrexia, by these signs you shall know it.—*Prof. J. T. Whittaker, Cin. Lancet and Clinic.*

CASCARA SAGRADA IN CONSTIPATION.—J. Fletcher Horne, F. R. C. S., writes: "*Cascara Sagrada, Rhamnus purshiana*, is a small tree indigenous to the Pacific coast of North America. The fluid extract I have used is that prepared by Parke, Davis & Co., Detroit, and procurable of their agents, Messrs. Burgoyne, Burbridges & Co., London. Its use, in my hands, seems to be indicated in almost all cases of constipation, particularly in cases of torpidity of the liver, with scanty dry stools and indigestion. It seems to act as a stimulant to the muscular fibres of the intestines, through its action upon the sympathetic nerve, this increasing the vermicular movements of the intestines, thus resembling *nux vomica*. I have used it in several cases of obstinate constipation with very satisfactory results. I generally give twenty drops three times a day in sweetened water for ten days or a fortnight; and then, gradually reducing this dose, the patient is able to establish a habit of regularity. Given in doses of a teaspoonful, it acts as a gentle purgative, without producing any griping tenesmus or nausea; but its action is slow, and in this sized dose, seems to lose its good property of curing the constipation. With children, with smaller doses, I have had equally good results."—*British Medical Journal.*

DIALYZED IRON.—A recent analysis by Professor Tichborne of Wyeth's preparation agrees almost exactly with Graham's statement, that dialyzed iron contains 98.5 parts of the oxide and 1.5 part of hydrochloric acid. The liquid thus obtained differs altogether from an ordinary solution of salts of iron, by its not giving rise to the blood-red color on the addition of alkaline sulphocyanide, nor to the blue precipitate with ferrocyanide of potassium. It does not become cloudy on boiling, nor when agitated with two parts of ether and one part of alcohol is the ether layer colored

yellow. It is so sensitive that ordinary spring water will cause a precipitate, yet no precipitate is produced by nitric, acetic, or muriatic acid. Graham's solution gelatinized in about twenty days, and he regarded it as a solution of colloid ferric hydrate which, he considered, existed in both a soluble and insoluble form. It is, however, never free from chlorine.—*Chemist and Druggist.*

TREATMENT FOR TAPEWORM.—After a light dinner, near the middle of the day, the patient should take no food, but may drink freely of water. At bed-time a saline aperient should be taken in effective dose, and there is nothing better than one or two Seidlitz powders. This aperient should be a saline, because these cause a copious effusion of serous liquid from the whole mucous membrane of the canal, and this effusion taking place from the surface where the head of the worm lies protected by the dense mucus, detaches the mucus and washes it away, leaving the head bare for contact with the parasiticide, when otherwise it would pass over it without direct contact, and, therefore, without effect.

Whether this aperient operates at bed-time or not, it should be repeated on the following morning, the patient still abstaining from food. After the second saline has operated freely; or say at about ten o'clock, the medicine should be given.

Four ounces of pumpkin seeds are well beaten in a mortar, half an ounce at a time, a few drops of water being added from time to time, until they are made into a paste. The shells need not be rejected, as they are rather useful than hurtful. Water is then gradually added to the paste, with trituration, until a tolerably uniform emulsion is made measuring about a pint. This may be flavored, if desired, and iced, and is to be given in three doses, at intervals of about two hours, beginning at about ten o'clock. During this time the patient should lie quietly in bed, and avoid all causes of nausea and vomiting, and should correct these, if they occur, by a little ice taken into the mouth and stomach. The stomach in need of food will often digest the first dose, but a tendency to nausea will prevent the digestion of the others, and the third is often difficult to take without vomiting. By careful management and quiet the inverted peristaltic action may generally avoided. But when it occurs early, and is persistent, the treatment is likely to fail, because the inverted action of the bowel prevents the emulsion from getting far enough down to come in contact with the head of the worm. Commonly, however, the peristaltic action will not be reversed, and about the time of the third

dose, or a little later, there will be an alvine evacuation. But if not within an hour after the last dose, a half fluidounce of castor oil should be given in a little ale or porter. The evacuations should be received in a vessel partly filled with water, so that the worm can be easily examined from end to end of each portion without breaking, and when the part is reached where the links grow smaller, great care should be taken to find the head, for unless this be found the success of the treatment is by no means assured. And if the head be not found, detached links may be expected in the stools within three or four months, and the treatment will need to be repeated, with larger preliminary fasting and greater care.

In the second trial, or when persistent vomiting has interfered with the first, to invalidate it, the oleo-resin of male fern may be substituted for the pumpkin seed. This is more easily taken than the large doses of emulsion, and is not so easily digested by the stomach, nor so liable to produce nausea, and from being an oleo-resin, and therefore less soluble in the liquids it meets with, it is more likely to reach the head of the worm in a condition sufficiently concentrated to be a poison to the head, but it is probably a less active poison to the head than the pumpkin seed, and therefore less sure.

The oleo-resin may be given in emulsion made with sugar and gum arabic, or with glycogen, but is perhaps better given in capsules containing about ten grains each. Two of these should be taken every quarter of an hour until twelve capsules have been taken, unless nausea occurs of sufficient severity to endanger their rejection. Under such circumstances eight or ten capsules may be used, as being all that can be safely given.

The oleo-resin has often, especially in cold weather, and when of good quality, a thick, granular sediment. This should be carefully stirred in before weighing, as it is a very important part of the drug.

Of course, the same careful preparation of the patient is needed with this as with the pumpkin seed, and neither of them should be expected to succeed in obstinate cases without the careful preliminary treatment.—

Dr. E. R. Squibb, in Ephemeris.

GOODELL'S FOUR CHLORIDES; an alterative tonic—

R Hydrarg. chlor. corr., gr. ij;
 Liq. arsen. chlor., ʒj;
 Acidi hydrochlor, dil.,
 Tr. ferri chlor., aa ʒij;
 Syr. zingib., ʒij;
 Aq., q. s. ad, ʒvj.—M.

Sig. Dessertspoonful in water after meals.

Vol. I.
 No. 10.—6

IN an essay entitled, "An Experimental Investigation of the Action of Chloral, Opium, and Bromide of Potassium," by Dr. Sidney Ringer, Professor of Medicine in University College, London, and Dr. Harrington Sainsbury, the authors make the following important observations on certain well-known drugs, after discussing the physiological effects of the agents mentioned in the title of their paper :—"Clinically, the dangers of bromide of potassium and of chloral have been recognized ; and thus in our text-books, we find the statements that the presence of grave adynamic symptoms contra-indicate chloral and bromide of potassium. Opium, on the other hand, in such adynamic states, frequently appears to lend actual support. The results of definite experiment we find to accord with the results of clinical experience ; and the value of the former lies in that they confirm, and by their definiteness must tend to enforce the teachings of the latter. The choice of a drug, is, however, no simple matter ; and advantage here may be outbalanced by a disadvantage there ; and practical men may object that they would gladly give opium, but that the disordered stomach, blunted appetite, inactive liver, and torpid intestines, more than outweigh the advantages of opium administration. This clearly is a matter for consideration in the individual case under treatment ; and the decision will have to be according as one or the other element, asthenia, or derangement of the digestive, etc., powers, is most to be feared. These objections to opium, on the one hand, and chloral and bromide of potassium, on the other hand, raise the question as to whether, in very many cases, a drug, at present rather extensively used, especially in America, viz., bromide of sodium, might not with advantage be substituted in their place. The salts of sodium generally contrast very markedly with those of potassium ; for the chlorides, bromides, and iodides of these two metals, the lowest figure would represent the potassium as ten times as active as the sodium. These precise numbers refer to action on the ventricle of the frog's heart (see *Medico-Chirurgical Transactions*, vol. lxx, concerning the action of the salts of potash, soda, and ammonia on the frog's heart), but on all hands the evidence is forthcoming that, whilst salts of potassium are very poisonous, those of sodium are very slightly so. One of the marked points of contrast between the two sets of salts is to be found in respect of inhibition ; potassium salts inhibit the frog's ventricle strongly, sodium salts scarcely at all. Here, however, we are considering drugs as to their cardiac effect ; and in respect of this sodium bromide would rank far ahead of bromide of potassium, chloral, or opium, as to innocuousness. The objections holding for opium would not apply here, for sodium salts are generally very little disturbing to the tissues. With these

advantages the general verdict of clinical experience is to the efficacy of bromide of potassium ; and should this position be maintained, it is clear that bromide sodium will be in very many cases the sedative above all others to be selected.”—*British Medical Journal*.

CHLORAL HYDRATE AS A VESICANT.—Dr. F. D. Ritter, of Gaines, Pa., writes to Dr. T. Gaillard Thomas, as follows: “In complying with your request, I write you concerning my experience with chloral hydrate as a vesicant. Some three years ago I accidentally discovered that when powdered chloral, sprinkled upon ordinary adhesive plaster and melted by a gentle heat (not more than enough to cause the plaster to adhere to the flesh), is applied while warm to the part where the blister is wanted, within three minutes a gentle heat is felt, increasing in intensity for about three minutes more till it is like a burn, then gradually easing off, until, at the end of ten minutes, the parts feel free from pain. The secondary effect is soothing; in some instances within half an hour a second burning is felt, though not so intense as at first, nor so lasting. If, at the end of ten minutes, or as soon as pain has subsided, the plaster be taken off, the surface is found as effectually denuded as by a cantharidal plaster after six hours, though the discharge is not so great. Thus, within ten minutes the work of an old-fashioned blister is accomplished; and the great advantages of the chloral plaster over the cantharidal are: 1st. Its rapidity of action, thus relieving pain, and producing the counter-irritation upon an engorged organ before the congestive action has had time to pass into more than the congestive stage; 2d. Its ease of application; 3d. It need never be taken off to have the blister dressed; but the original plaster may remain until the sore is entirely healed, and the plaster loosens and comes off itself. This is in part my experience, and I would have given it to the profession before, but supposed it was well known.”—*New York Medical Journal*.

SPRING DIET.—As the warm weather advances it is usual with most families to use the various forms of pickles, salads, greens, sauer kraut, anything that will admit the use of vinegar. All of this is suggested, so far as the appetite is concerned, by the demands for acids. It might be very well if the articles with which the vinegar is combined were wholesome, which is not true. Many of these are so crude and unripe as to counteract all the good effected by the acids. I have long been accustomed to obviate this unusual craving for objectionable acidulated foods by the moderate use of the Acid Phosphate of Prof. Horsford in a reduced

form, taking it with the meals or at any time when one is thirsty. Since it is a food drink, I prefer it to ordinary lemonade. This Phosphate is a food for the nerves, far superior to the usual nervines for that unfortunate class who seem compelled to take medicine for the nerves most of the time, since its action is not in the direction of quieting them. When suffering from disease, these nerves very properly utter an alarm, a protest against their cruel treatment, when cloves and all sorts of irritants are freely used, becoming unstrung. They are weakened, jaded, worn out, needing nutriment far more than quieting. This nourishment, this "tonic," is found in the "Acid Phosphate" in a better form, according to my experience for many years, than in any article with which I am acquainted. In the family use we feel that we are benefited in the matter of digestion, while it stimulates the liver to do its work more perfectly.—*Dr. J. H. Hanaford.*

GASTRIC IRRIGATION.—This operation is becoming every day more recognized as useful in suitable cases. Bianchi relates four cases: 1. Chronic gastritis, simulating cancer, pains in the right side, great emaciation, vomiting of food and blood, followed by relief. Many remedies were tried with no good effect until irrigation of the stomach with water at 53.5° or 58° F. was resorted to. The patient felt better the same day. The irrigation was repeated every morning, at first with plain water, afterwards with water containing two drachms of bicarbonate of soda to the quart. The patient was discharged cured in a month, having gained 15 pounds in weight. 2. Chronic catarrh (drunkard's), with probable pyloric stenosis of inflammatory origin. There were pyrosis and vomiting of food, preceded by pain in the epigastrium; cure, in a month. 3. Gastric catarrh, with marked dilatation of the stomach. Great improvement followed in three days, when the patient left. Carcinoma of stomach; fixed pain in the pyloric region, vomiting of blood. The patient experienced much relief from the irrigations, and was able to take liquid nourishment, and gained strength for a time, but died after a month, worn out by the cachexia and debility.—*London Med. Record.*

WHERE liver congestion exists to a decided degree, the following is of service:

R. Cinchonidæ Sulphatis, Euonymin, Iridin, Leptandrin, Juglandin, aa, 3 ss; Podophyllin, Ext. Belladonnæ, Ext. Nucis Vomica, Ext. Hyoscyami, aa, grs. x. M. In pil. No. 60 div. Sig. One or two at bedtime.

Many a stubborn case of dyspepsia, that had run the gauntlet unavailingly of all sorts of peptonoids, has given way to this, and it is an admirable cholagogue on general principles.—*W. R. D. Blackwood, M. D., Phila. Med. Times.*

REVIEWS AND BOOK NOTICES.

Prices are always inserted when furnished by the publisher, or when obtainable from the bookseller.

A Manual of Histology.—Edited and prepared by Thomas E. Satterwaite, M. D., of New York, in association with Drs. Thomas Dwight, J. Collins Warren, William F. Whitney, Clarence J. Blake, and C. H. Williams, of Boston; Dr. J. Henry C. Simes, of Philadelphia; Dr. Benjamin F. Westbrook, of Brooklyn; and Drs. Edmund C. Wendt, Abraham Mayer, R. W. Amidon, A. R. Robinson, W. R. Birdsall, D. Beyson Delavan, C. L. Dana and W. H. Porter, of New York. Second edition, enlarged and revised, containing two hundred and two illustrations, with an appendix. New York, William Wood & Co. 1882. Pp. 490.

Only a few months ago we had the pleasure of offering some favorable comments upon the first edition of this work, the popularity of which has rendered, at this early day, a second edition necessary.

The text has not been changed except to correct typographical and other unimportant errors, but such discoveries as have been made in histological investigations since the appearance of the first edition are noted in the appendix. We can freely commend the book.

Manual of Gynecology.—By D. Berry Hart, M. D., F. R. C. P. E., and A. H. Barbour, M. A. B. Sc. M. B. Vol. I. with 8 plates and 192 cuts 8vo., cloth; 314 pages. Vol. II: with one lithograph and 210 wood cuts. 8vo. Pages 366; with full index. Wm. Wood & Co., New York. 1883.

These are the initial volumes of *Wood's Library of Standard Medical Authors*, for 1883. In appearance they are an improvement over the *Library* for the past year, and are certainly samples of elegant book-making. The efforts of the publishers in the past seem to have been duly appreciated and to have incited them to still greater efforts for the future. The quality of the paper is superior, and the binding is more substantial than in former series. The two volumes form in fact a manual, based, as claimed by the authors, on the anatomy, physiology and pathology of the pelvic organs, and as such they enter into all the minutiae of the entire subject. The anatomy of the parts, instruments, methods of examination, operations, and everything are given with reference to those little details which are most desired by the general practitioner. The literature of each subject receives full attention, and the bibliography is full. Although there are many works on this subject, we know of no one which will satisfy the non-specialist better than this.

Practical Treatment of Diseases of the Skin, for the Use of Students and Practitioners. By James Nevins Hyde, A. M., M. D., Professor of Skin and Venereal Diseases, Rush Medical College, etc., etc. Philadelphia: Henry C. Lea's Son & Co. 1883. Pp. 572.

The skin men of the profession have been unusually active of late years. We believe the book before us is the first of its kind to appear west of the mountains, and it will certainly lose nothing in comparison with those of the east.

Dr. Hyde's book is deserving of a place in every physician's library, and cannot fail to add to its author's already extensive reputation.

But in spite of all the books and beautiful atlases that have recently been published, the diagnosis and treatment of skin diseases, excepting a few plain ones, are undertaken by the ordinary practitioner with no little dread and misgiving.

Labor Among Primitive People. Showing the Development of the Obstetric Science of To-day from the Natural and Instinctive Customs of All Races, Civilized and Savage, Past and Present. By Geo. G. Engleman, A. M., M. D., Professor of Obstetrics in the Post-Graduate School of the Missouri Medical College, etc. Fifty-nine Illustrations. St. Louis: J. H. Chambers & Co. Second edition, Revised, Enlarged and Re-arranged. 1883. 8vo. Pp. 203. Cloth

We noticed the first edition of this curious book only last October. The author has added some details in the present edition, and re-arranged some of the chapters. It is a wonderful compend of ethnology, as relates to the one topic.

Experimental Pharmacology. A Hand-book of Methods for Studying the Physiological Action of Drugs. By L. Herman, Professor of Physiology in the University of Zurich. Translated, with the author's permission, with Notes and Additions, by Robert Meade Smith, M. D., Demonstrator of Physiology in the University of Pennsylvania. With 32 Illustrations on wood. Philadelphia: Henry C. Lea's Son & Co. 1883. Pp. 201.

The title of this book well indicates its scope. It will prove an inestimable boon to those commencing to experiment in this direction, and medical students, during the summer vacation, could not do better than devote themselves to such work as preliminary to a little originalty in thesis writing.

Official Hand-Book of the Dramatic Festival, Held in Music Hall, Cincinnati, April 30—May 5, 1883. Edited by Montgomery Phister, Cincinnati. Published for the Dramatic Festival Association, by H. C. Hall.

There is a large amount of information contained in this elegant hand-book, and parties proposing to attend the Festival can not do better than secure a copy. The publisher has done his work in fine style.

COLUMBUS MEDICAL JOURNAL.

EDITORIAL.

RETROSPECT—*Pharmaceutical.*

The Wm. S. Merrell Chemical Co.'s *Resinoids* and *Alkaloids* are not excelled for *purity* and *reliability*. Sulph. Hydrastia (Berberina) in Crystals; as well as the Muriate, Phosphate, and Principles Combined; Podophyllin, Leptandrin, Nitrate Sanguinarina, and many other leading articles in these lines *originated* with them, and were brought to *present perfection* through their investigations.

Pure Salicylic Acid from Oil Wintergreen is one of the *fine specialties* of the Wm. S. Merrell Chemical Co. It is equal in purity to the finest German imported, which is sold in powder and liable to *adulteration*. The Crystalline form of the Wm. S. M. Chem. Co. preparation is a protection against this growing evil.

Nitrate Sanguinarina—Introduced by the Wm. S. M. Chem. Co.—For extended notes on this preparation send for circular. In *Croup*, Scarlatina, Diptheritis, Pseudo-Membranous Croup, Nitrate Sanguinarina has proved to be almost a specific; not only relieving the inflammation of the fauces, but also dissolving the adventitious formation.

The *Green Drug Fluid Extracts* of the Wm. S. Merrell Chemical Co. challenge comparison as to medicinal strength, physical appearance, and positive therapeutic efficacy. As a *secondary* consideration we may add that an average saving of nearly *one-third* is gained by their use, especially by those physicians who have been paying exorbitant prices for the use of the copy-righted label "*Specific Medicines*."

Hydrastia—Pure White Alkaloid, in crystals.—This Alkaloid exists in the root in very small proportions. It is coming into use, however, triturated with Sugar of Milk; and also in combination with Subnitrate Bismuth in the preparation introduced by the Wm. S. Merrell Chemical Co. as "*Solution Bismuth and Hydrastia*."

"Specific Medication" is the practical application of a correct theory;—the use of the *so-called* "Specific Medicines," under an impression that they are essential to the *success* of the principle, is a fallacy, which is thoroughly exposed in our paper—"The Fluid Extracts of the Wm. S. Merrell Chemical Co. vs. the *so-called Specific Medicines*." The argument therein has never been answered. Send for a copy.

The great success attending its sale is convincing proof that "*Fluid Hydrastis*" *perfectly fulfils* the indications for its use suggested in the circular issued by its originators, the Wm. S. Merrell Chemical Co.

Messrs. BRAUN & BRUCK, Wholesale Druggists, *Columbus, O.* are agents for the Wm. S. Merrell Chemical Co.'s Preparations. Physicians may obtain from them any article made by this "Co." If not in stock, it will be furnished at short notice.

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We have no *authorized Collectors*, except such as carry properly made out bills, *counter signed by the Publishers*.

HANN & ADAIR, Publishers, Columbus.

THOSE TOLEDO SCHOOLS.

MANY of our readers have doubtless already received the announcement of the *Toledo Medical College*, and, probably, also the prospectus of the *Northwestern Ohio Medical College*, of Toledo.

When the "Toledo School of Medicine," of which the latter college is the direct outcome, was organized in 1878, we took occasion to predict that it would soon evolve into a college, but we little thought it would be *twins*.

It is, of course, always safe to assume, when two colleges thus start together, that there is an interesting "inside history," which does not appear on the surface. We have taken some pains to get at these inside facts, and we will now present them as briefly as possible.

In 1878, when the "Toledo School of Medicine" was organized, the profession of that city seemed to be almost phenomenally united and happy; so much so that it was a matter of comment. But at that time some of the doctors allowed ambition—"by which sin fell the angels"—to possess their souls, and so started the school. At once, grim-visaged war appeared, and the struggle commenced between the "ins" and the "outs." The "outs" started a new medical society, and the opposition became fully organized.

But the "school" languished, from the fact that its course was only recognized as so much time spent in study, and finally, a year

ago, failed entirely. This failure, however, was only designed to be temporary, as the forces were engaged in organizing the regular college. In the meantime the opposition had not been idle. In fact they got their charter first, and, by taking the name of Toledo Medical College, stole a march on the others. (It is intimated that they stole the name, too; but that is a point too subtle for discussion here.) In order to get the necessary \$5,000 to secure a charter, the eleven members of the faculty gave their individual notes for \$500. (Of course we hope the notes of Toledo doctors are *good*: but doctors are generally so impecunious that their notes sell *by the pound*. They ought to have adopted the scheme of issuing \$5,000 worth of "stock;" one school that we know of has such a "foundation," and its diplomas are recognized still in—a majority of the states.) The "school" men, though anticipated, were not beaten, but changed their name, subscribed the necessary amount, and secured their charter.

For such a state of affairs to exist and not produce a medical journal—as a sort of "afterbirth," so to say—would be almost unheard of. So, sometime in January, along came the "*Toledo Medical and Surgical Journal*, Vol. v., No. 1;" and then came an injunction suit, as this was regarded as another case of *appropriation* of names (What a flood of memories crowd on us as we write!), and the epitaph of the young "Vol. v.," was written. It may be that it is only sleeping, but if born again it must be with another name; still, if "a rose by any other name could smell as sweet," certainly a medical journal would read as well.

And so two schools exist—subsist would perhaps be more expressive and appropriate—in Toledo, and the profession there is far from happy. One school is a summer school and is now in session with, we are informed, about a dozen students. The other school will have its regular winter session. The school now in operation claims no hospital whatever, and the entire matter of clinics is scarcely mentioned in its announcement. The other school has a hospital, at least, and will organize a free dispensary. Neither school makes any claim to any special facilities for instruction, or extra requirements for graduation; the minimum of everything is the standard, and "what trick, what device, what starting hole" either school can find to explain its existence, is a mystery. In the hope

that it will prove a case of Kilkenny cats, the profession can bid them both God speed. Six months ago, the stand taken by the Illinois Board of Health would probably have prevented the birth of either school; but its recent pusillanimity has made it the laughing stock of the country, and utterly destroyed its usefulness.

We, of course, hope that each school may demonstrate its fitness for the work before it, but we see no reason to expect it.

(It is said that one of these schools tried to be taken under the wing of the University at Delaware—and here comes another flood of memories!—but the rivalry of the school interests at Cincinnati and Cleveland prevented the consummation, by the significant vote of 8 to 7).

CROUP AND DIPHTHERIA.—Our readers can bear testimony that the interminable question as to the identity of these two diseases has not been much discussed in our columns. We have broken over our rule in the present issue, by admitting the discussion of the Central Society. The discussion was undoubtedly above the average, but no converts were made by either party; as, indeed, is usually the case when that topic is brought forward.

In our opinion the diseases are identical. Tuberculosis of the lungs, has a different symptomatology from that of the mesentery or brain: a gun-shot wound of the brain produces very different symptoms from one of the muscles or great cavities; so a false membrane in the larynx, is accompanied by different symptoms from one in the pharynx or elsewhere. In one case death results speedily, from asphyxia; in the others, more slowly from asthenia, or blood-poisoning. The remote cause of death is the same, the immediate cause different. A few weeks ago we were called to a case of true croup, in a child of four years. There was no sign of pharyngeal involvement whatever; the membrane was limited to the larynx. The breathing becoming more and more difficult, and, the child being moribund, we performed tracheotomy. The improvement was immediate and great. The breathing was perfectly natural, the pulse fell from 170 to 120, food was taken readily, and the child even wanted to get down onto the floor to play. Twelve hours after the operation, everything seemed favorable for recovery. Two hours later, the membrane appeared in the trachea, covering the edges of the wound, and producing dyspnea. Removal of this membrane, by dressing forceps and small probang, resulted in temporary improvement in respiration, but soon the deposit appeared lower down in the bronchial tubes, and death occurred speedily, by asphyxia. There

was at no time evidence of pneumonia, nor of an extension of the membrane to the pharynx or soft palate. It was a typical case of diphtheria, involving only the air-passages. Had the membrane not extended after the operation, the child would have recovered, or died of asthenia or blood-poisoning—as in pharyngeal diphtheria.

In brief; we regard the disease as the same, but the difference in the location of the membrane results in the difference in symptoms and in the mode of dying.

COMPOUND SYRUP OF IPECAC.—Dr. R. Harvey Reed, of Mansfield, O., recommends the following:

R Tr. Opii deod., ℥ij;
Tr. Ipecac, deod., ℥i;

M., and filter through ordinary filtering paper. Then add,
Syr. q. s. ad., ℥xvj.

One teaspoonful is an ordinary dose for an adult, and represents about five grains of Dover's powder. In making the tincture of Ipecac, use—

Ext. Ipecac, U. S. P., ℥i;
Deodorized alcohol, ℥vij;

M., and filter through paper, adding deodorized alcohol, q. s. to measure ℥vij.

This syrup will be found equal, if not superior, to the copy-righted article sold everywhere for a dollar a pound, and can be easily made for from fifty to sixty cents a pound by any physician or his druggist.

THE AYES AND NOES ON THE NEW CODE—The ayes and noes of physicians from New York City on Dr. Squibbs' resolution, at the last meeting of the State Medical Society, to abolish the new code adopted at the previous meeting, were as follows:

Ayes. John G. Adams, J. W. S. Gouley, John H. Hinton, Robert Newman, Francis V. White, William T. White, C. S. Wood—7.

Nays. C. R. Agnew, W. T. Alexander, W. R. Birdsall, W. M. Carpenter, F. A. Castle, C. L. Dana, F. R. S. Drake, Louis Elsberg, Geo. H. Fox, Frank P. Foster, Robert M. Fuller, A. G. Gerster, V. P. Gibney, Emil Gruening, A. Hadden, J. W. Howe, A. Jacobi, A. M. Jacobus, L. Johnson, H. Knapp, D. Lewis, J. L. Little, A. V. B. Locknow, W. F. Mittendorf, Paul F. Munde, E. L. Partridge, H. G. Piffard, O. D. Pomeroy, T. R. Pooley, J. H. Ripley, D. B. St. John Roosa, S. Sexton, G. F. Shrady, A. H. Smith, F. R. Sturgis, S. O. Wanderpool, David Webster—37.

And yet we are told that it was not a movement of the specialists!

BROMIDE OF ETHYL AS AN ANESTHETIC, is again being brought forward. The profession will not, however, be likely to forget the fatal cases which caused its abandonment soon after its introduction. In this connection Dr. J. C. Reeve, of Dayton, O.,—than whom on anesthetics there is no higher authority—publishes a note of warning, in the *Medical News*, recalling his personal experience with the drug. He had it administered to himself three times, and in each instance the pulse showed a very great and rapid increase of rate. The figures were—from 80, before inhalation, to 100; from 80 to 120; from 78 to 120—as observed by medical friends who were present. This great change took place *within the first minute, or minute and a half, of inhalation!*

LACTOPEPTINE, manufactured by the New York Pharmacal Association, 10 and 12 College Place, New York, has become one of the every-day remedies of the profession. It is prepared with the most scrupulous care, and has the endorsement of the leading physicians of this country and Europe. As a remedy in dyspepsia and allied ailments it is invaluable. From past experience with it in diarrheal disorders of infancy we cannot too highly recommend it to our brother practitioners. We have also used it with good results in the nausea and vomiting of pregnancy.—*Miss. Val. Med. Mo.*

CINCINNATI SANITARIUM.—We have read with interest the annual report of the Superintendent of this institution, which contains many practical observations relative to the care of such cases as usually seek relief in retreats of this character. Those who have imbecile or insane relatives can secure for them the best professional aid, with home-like advantages, at this Sanitarium.

THE PLANET is the name of a new medical journal recently started in New York city. Its programme announces “no advertisements, no copying, all original articles, no rejections.” Published by Dr. C. E. Nelson, 109 E. 35th street, monthly. Price \$1.00 per year. Under the above programme, it can hardly prove other than a comet.

DR. J. H. POOLEY has removed with his family to Toledo, having the professorship of surgery in the Toledo Medical College. It is to be hoped that the change will improve his health, which has been so broken here as to have incapacitated him for all work for nearly a year and a half.

BEGINNING with May 3d, 1883, the *Maryland Medical Journal* will be issued as a weekly. Each number will contain sixteen pages of reading matter. The size and appearance of the *Journal* will be slightly altered to conform to the new requirements.

MESSRS. JOHN WYETH & BROTHER offer to the profession Fehling's Test Tablets, for the rapid and accurate detection and estimate of sugar in the urine in diabetes. They are put up in convenient form, and are accompanied by full directions for use.

CORRECTION:—In our last issue, in Dr. Morse's article, page 397, third line from bottom, read, "want of prudence, caution and judgment were the *effects* of the disease," etc.

SOCIETY PROCEEDINGS.

CENTRAL OHIO MEDICAL SOCIETY.

THE society convened in the Board of Trade room, City Hall, Columbus, on Thursday, Feb. 1, 1883, and was called to order by the President, Dr. Woodruff.

Dr. Pooley then reported a case of calculus in the kidney in a female, 25 years of age, which he was treating with preparation of iron, ergot, matico. etc.

Dr. T. W. Jones spoke of the importance of physicians taking some action corresponding to the action of druggists in securing reliable drugs. Dr. Marshall referred to the Wisconsin law, that no druggist should be allowed to duplicate a prescription of a physician without his order—and thought it a good provision. Dr. Landon suggested that Dr. Jones should formulate some plan and present it to the society, by which they might secure more reliable drugs from our druggists, and the relations between physician and druggist be better understood. The subject had been discussed in the society, but no definite action had been taken. On motion of Dr. Landon, a committee consisting of Drs. T. W. Jones, Hyatt and Pooley, was ap-

pointed to report at the next meeting on the relations existing between the physician and druggist.

Dr. Guerin then opened the discussion on the question, "What is the Difference in the Pathology of Pseudo-membranous Croup and Diphtheria?" In a paper of some length he gave what he considered the pathological distinctions, and cited different authors which sustained him in his views.

The subject was discussed by Drs. Pooley, Sharp, Helmick, Dunham, Marshall, Frankenburg and Pratt. Adjourned.

O. JOHNSON, M.D., Sec'y.

NORTH-EASTERN OHIO MEDICAL ASSOCIATION.—At the annual meeting, on February 6th, the following officers were elected for the ensuing year:

President.—Dr. J. W. Underwood, of Akron.

First Vice-President.—Dr. R. A. Vance, of Cleveland.

Second Vice-President.—Dr. B. P. Loughhead, of Windham.

Recording Secretary.—Dr. L. S. Ebright, of Akron.

Corresponding Secretary.—Dr. A. K. Fouser, of Akron.

Treasurer.—Dr. E. W. Howard, of Akron.

OBITUARY.

WILLIAM HOLME VAN BUREN, M. D., L. L. D. (Yale), died March 25th of paralysis.

He was born April 5, 1819. He graduated from the Medical Department of the University of Pennsylvania, in 1840, having spent some time in study in Paris. He served five years as an Army Surgeon, marrying during that time a daughter of Valentine Mott. In 1852 he became Professor of Anatomy in the University of New York. In 1868 he became Professor of Surgery at Bellevue, which position he held until his death.

His published works consisted of translations of Morel's *Histology*, and Bernard and Huet's *Operative Surgery*; *Contributions to Practical Surgery*, 1865; *Lectures upon the Diseases of the Rectum*, 1870, and 1881; and a text book on *Diseases of the Genito-Urinary System with Syphilis*, with Dr. E. L. Keyes, in 1874. In addition to these he published many articles in the medical journals, including a recent contribution on the subject of litholapaxy; a paper on "Aneurism," read before the International Medical Congress, in Philadelphia, in 1876, and (his last work) the article on "Inflammation" in the *International Encyclopedia of Surgery*, a paper in which his large experience, wide reading, sound judgment, and broad and scientific views appear to great advantage.

NOTES AND COMMENTS.

THE STRUGGLE FOR A LIVING.—The following is from the presidential address, to the Maine Medical Association, by the late William Warren Greene, M.D. :

“Witness the large number of doctors in every city struggling for a mere existence, and see how few out of the whole number really do the work. See how in almost every country village a full practice for one or two good men is piece-mealed by sharp and often acrimonious competition to the detriment of all.

“It would seem that in a calling so high, so noble, so sacred, men for such ministry should be sought for ; but the great question of the young graduate is not ‘Who wants me?’ but ‘Who will employ me?’ not ‘Who needs me?’ but ‘Where am I to get a living?’ In the case of four physicians dying, each in a country village, during the last year, I am credibly informed that in one instance two, in another three, in the third five, and in the fourth case seven new men came to look the field over within ten days after the doctors’ death, sometimes before the burial. In one case two attended the funeral, and in another the widow had three letters from aspirants for the vacant place while the dead body of her husband still lay in the house.

“It is a hackneyed saying, with which too many ears are tickled, that ‘there is always room for good men.’ Applied to the present condition of our profession it is false. Were only good men and the best men admitted it would undoubtedly be true. But all over the land, in city and country, are well-educated, cultured gentlemen, honest and loyal, striving in vain to secure a competence—yes a bare living even—and too often is disappointment mingled with shame and mortification at the success of ignorant and unprincipled rivals. I have said that the evil results of this excess in members are manifold. It leads to over-practice and to bad practice. The man who is hard pushed, who has few patients and needs more, is tempted to make much of little ; to magnify the importance of his cases, both in his own mind and to his patrons ; to make uncalled-for visits, and to give too much medicine ; and unnecessary medication soon ceases to be rational. Patients are injured in mind and body. The community is injured by teaching people to attach undue importance to trivial diseases, and to over-estimate the value of treatment therein. Legitimate, honest practice suffers in reputation ; money is obtained under false pretences.”

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COMMUNICATIONS.

THE DIAGNOSIS OF INSANITY.

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MELANCHOLIA AND HYPOCHONDRIASIS.*

* * * * * "forgotten quite
All former scenes of dear delight,
Connubial love—parental joy—
No sympathies like these his soul employ;
But all is dark within."

—Penrose.

"Methinks I hear, methinks I see
Ghosts, goblins, fiends; my phantasy
Presents a thousand ugly shapes,
Headless bears, black men, and apes,
Doleful outcries, and fearful sights,
All my griefs to this are jolly,
None so damn'd as melancholy.

"I'll change my state with any wretch,
Thou canst from gaol or dunghill fetch;
My pain 's past cure, another hell,
I may not in this torment dwell!
Now desperate I hate my life,
Lend me a halter or a knife;
All my griefs to this are jolly,
Naught so damn'd as melancholy."

—Burton.

In our last we described that state of exaltation known as mania; in this we will consider a condition of which the essential features are characterized by depression—melancholia. The one is characterized by expansion, self inflation, vanity, action, a more objective state; the other, concentration, limited views, self depreciation—subjective symptoms. I do not mean by this that all views entertained by the patient of himself are narrowed, for on the contrary the actual condition of the person, the amount of disease or danger, is grossly exaggerated, and this exaggeration

*Delivered at Starling Medical College, January 19, 1876.

is that which tends to give alarm and suffering to the patient. Fear is a predominant element, and this colors all thoughts and acts where the intellect is apparently involved. A dread of something, they know not what, an ill-defined sense of danger, anxiety, impulses to flee from everything that can in any way be tortured into evil, apathy, indifference, immobility with some, with all, fear, gloom and despair. Dryden is often quoted to express it—

“He makes his heart a prey to black despair,
He eats not, drinks not, sleeps not, has no use
Of anything but thought; or, if he talks,
’Tis to himself.”

Mania and melancholia have from the earliest times been recognized as forms of insanity; mania, characterized by furor, melancholia by fear.

Hippocrates* referred all insanity to the brain, and distinguished melancholia by the want of violence. He says: “If fear or distress continue for a great length of time it indicates melancholia.” Many writers have classed melancholia as a monomania, on account of the limited trains of thought—the paucity of ideas. Partial insanity, whether gay or sad, has been termed melancholia. Rush used it in this sense. Esquirol termed it *Lypemania*, from two Greek words signifying sadness and mania, but used the term as synonymous with melancholia. He described it as a cerebral affection characterized by a partial chronic delirium, without fever, maintained by a mournful, debilitating, or oppressive passion.” He regarded it as the opposite of monomania. Most of the early writers, and they are legion, regarded the seat of the disease in the digestive organs, some in the head. When we analyze carefully what they have written we find that many of these first are but cases of dyspepsia with hypochondriasis.

Melancholia may vary in intensity of degree from a feeling of gloom and sadness to the most profound stupor. It may be a feeling of discouragement.

“Ah, there are moments for us here, when seeing
Life’s inequalities, and woe, and care,
The burdens laid upon our mortal being
Seem heavier than the heart can bear.”

—Phæbe Cary.

Many fall into a state of melancholia from mere force of habit. It is cultivated. The poet says, “by seeming gay we grow to what we seem,” and the contrary must be true if reversed. Want of occupation, if the mind be employed in idle and visionary wanderings, begets a love for solitude and melancholic contemplations.

**De la Maladie Sacrée*.—Translated into French by M. Littré.

"When I go musing all alone,
Thinking of divers things fore known,
When I build castles in the air,
Void of sorrow and void of fear,
Pleasing myself with phantasms sweet,
Methinks the time runs very fleet.

All my joys to this are folly,
Naught so sweet as melancholy."

—Burton.

Giving way to gloom and ill humor lays the foundation for melancholia. Winslow says: "Only wear a mask for a fortnight and you cannot tell it from your real face." The seeds when they begin to take root should be destroyed; an attempt should be made to rise above the depression by an effort of the will.

The faint shades of melancholia may be only a diminished self-confidence, self regard, a want of self reliance. In reviewing life's works there is a sense of unworthiness, and exaggeration of its misfortunes.

"Melancholy is a fearful gift,
What is it but the telescope of truth?
Which strips the distance of its phantasies,
And brings life near in utter darkness,
Making the cold reality too real."

—Byron.

It may be but remorse—the reflections of one conscience stricken—the mirror of an ill spent life. Man carried along on the tide of passion is self confident, enthusiastic, bold, and lives only in anticipation. A failure to realize these anticipated pleasures, their complete inability to satisfy his longings if he does, and the craving for something they have not afforded, leaves man often in a deplorable mental state. The *pursuit* of pleasure is often the only satisfaction afforded, for when the object is attained, all pleasure then vanishes.

"Our hopes, like towering falcons, aim
At objects in an airy height,
But all the pleasure of the game
Is afar off to view the flight."

—Prior.

A mind wrecked by giving free rein to passion is one full of darkness and a prey to torture; wreck of body goes with it hand and hand, and fortunate is the man if his unbridled lusts have not burned out the substance of his life, leaving only the ashes—hopeless dementia. The depression which results correlates the passion, its cause. Passion is like an insane impulse which sweeps all before it, and dying away leaves only grief that greater effort was not made to control it. Man despises himself for his weakness, yet seems powerless to arise and exert his strength.

"Oh, how the passions, insolent and strong,
Bear our weak minds their rapid course along;
Make us the madness of their will obey;
Then die, and leave us to our griefs a prey."

—Crabbe.

How many leaders of men, how many who have been the glory of their country, have through their vices, sunk into grief and despair. Great intellectual force is often without the support of moral power.

“Exalted souls
Have passions in proportion violent,
Resistless, and tormenting; they’re a tax
Imposed by nature on pre-eminence:
And fortitude and wisdom must support them.” — *Lillo's Elmerick.*

Melancholia, springing up as it were spontaneously, or as the result of heredity, or with one who naturally loves seclusion, is rather encouraged by the subject than opposed. To many of these gloom is happiness. I have often thought they are never so happy as when they are miserable. They are like the man who prayed for misfortune to come that it might cause him to lose flesh, but when it did come he was so pleased by it that he grew fatter. Buried in their own thoughts, surrounded by an impassable wall of reserve, they retire within their fortress, leaving not even an outside sentinel to be captured. There is no way to reach them; they desire nothing better than to be left alone with their thoughts.

“Go, you may call it madness, folly—
You shall not chase my gloom away;
There’s such a charm in melancholy,
I would not, if I could, be gay.” — *Rogers.*

How many have been thwarted in their efforts to relieve nervous disorders on account of this feeling? How many patients would rather cultivate their abnormal feelings than be relieved? How much this increases the labor of penetrating into the confidence, and esteem, and of securing that co-operation so desirable to facilitate recovery. This state, when hysteria gives it color, is often more discouraging and vexatious than when the mind is completely overcome, and in the profound gloom—

“Black melancholy sits, and round her throws
A death-like silence, and a dread repose;
Her gloomy presence saddens all the scene,
Shades every flower, and darkens every green,
Deadens the murmur of the falling flood,
And breathes a browner horror on the wood.” — *Pope.*

PRODROMIC PERIOD—INCUBATION—INVASION.

We have already given at some length the details of the melancholic stage of mania. Much that we have said will apply equally well to our present subject.

The primary seat of disorder is in the sensibilities, it is one of feeling, and in simple cases extends no further. It may begin as a simple feeling of distrust, of suspicion, of some impending evil, or misfortune, which from day to day gains ground, and at last invades the whole intellectual

field, overpowering the will and causing complete subjection of feeling, thought and action. It may be only vague, uneasy, gloomy feelings, with perhaps headache, insomnia, disorder of digestive organs and evidence of disturbance of physical system. If at this period, the incipient, there is any notable difference between mania and melancholia it is in the tendency to fixed, and limited ideas, the more manifest apathy and indifference, the greater disposition to seek seclusion, to sit motionless, revolving in their mind the sad state they regard themselves as suffering. There may be fears for themselves, it may be for others, but fear is early manifest. Sensibility is exalted, i. e., sensibility in the metaphysical sense, sensation is often almost abolished. Nutrition often shows disturbance early in the disease. With both mania and melancholia there may be fear at this period that they may become insane, yet this is no conclusive evidence of impending insanity, for many fear it all their lives who never become insane.

Melancholia has been regarded as a moral pain, mania the reaction against it, just as involuntary contraction of muscle takes place in pain of muscles.

The simplest form of fixed idea is that where a man cannot exercise reason or judgment beyond his own immediate beliefs. There is little difference between this and the fanatic who would shed blood for opinion's sake. Epidemic delusions which have deluged the world with blood are only the same on a larger scale. Unbelief, doubt, skepticism, intolerance of opinions of others, inability to receive evidence that contradicts their beliefs, is characteristic of many not regarded as insane. I should have stated while upon the subject of imbecility that this state of mind is frequently as clear evidence of imbecility as unlimited credulity is. Many skeptics who pride themselves upon their intellectual power are to such extent imbecile. Their minds cannot grasp truth, cannot receive facts, analyze them and make inductions. Their minds are narrowed and limited, and they will never believe otherwise than as they do, for they are incapacitated by nature from enlarging their reasoning faculties, and although they make a great deal of noise and confusion in the world, the fact comes home to them sooner or later that they are shallow and pretentious, and die from mental inanition. At this early period of melancholia there is often great anger manifested if they are annoyed by efforts made to discover their thoughts, or to advise them, or interfere with their conduct, but not that active furor and tendency to violence that character-

izes mania. There is instinctive violence rarely—the impulses less seldom becoming uncontrollable than with mania.

They may threaten, but seldom act. I have seen two or three attempt to strike with a chair, and two who kicked violently; one lady who was intensely suicidal and melancholic, who attempted to scald herself to death, was, when interfered with, extremely violent, but if left to herself, would sit for hours motionless and lament her lost condition. These cases had, however, passed the prodromic period, or had entered upon a pretty well developed melancholic state.

There is much less of violence due to delusion, in both mania and melancholia than is alleged by many writers. In fact, nine-tenths will be found by a careful observer, who will analyze the mental state, to be due to emotional disturbance which paralyzes the will, rather than to any idea or intellectual state. More patients will declare, "I don't know why I did it—something forced me to do it," than will declare it was from any motive which delusion determined. The old idea that if you refer to a man's delusion violence will follow, is only in rare cases true. The patient who loses his personal identity may become angry if called by his real name, much more so than if called by any other he has not assumed. Patients who commit acts as a result of delusion do it from the promptings of the impulse the delusion creates, and not from outside influence as a rule.

Now, that kindness and sympathy have taken the place so largely of restraint and abuse in the treatment of insanity, there is less violence—intelligent men no longer chain and punish, hence much stimulus to furor and violence is avoided. It is rare that the result as given by the poet may be seen—

"But if you hit the cause that hurts his brain,
Then his teeth gnash, he foams, he shakes his chain,
His eyeballs roll, and he is mad again."

—*Lee.*

The furor excited in melancholia is of less aggravated form than in mania, there is less incoherency. Greisinger says of this, it is a super-excitation and general agitation rather than a real mania. Baillarger, the French translator, says in a foot note, "it is due to instinctive impulse rather than delirious conception." This is, as we have said, no less true of many cases of mania, there is no recognizable delirium associated with the violence.

Griesinger terms the apathy and indifference, moral anesthesia—if it extends to stupor will is abolished. The stimulus, emotion, is wanting.

We have discussed before at considerable length the relation of the sensibilities to the will, the influence of emotion in determining volition. We cannot repeat it, further than to say that emotion precedes volition. Emotion excites volition, and in mania the emotional state produces excessive action, while in melancholia the apathy, want of emotion, leaves no stimulus. There is no goad or motor power. The function of the will is in part to control emotion, and repress it, but in mania it may subject the will. In melancholia there are limited ideas, thoughts revolving in a circle, there is an absence of impulse, or only such as results from the disordered emotions. Thus, fear of arrest by officers may cause a patient to escape from his house and run away. What action there is, is in the line of these emotions and delusions. If due to delusion, the delusion creates emotion, and the emotion excites action. The early stages of melancholia show want of harmony in the sensibilities. There is a change of habits, loss of interest in personal affairs, and yet while indifferent the patient may be tortured with a feeling that some calamity will come upon his family, that they will come to want. This disorder of the emotions is present to a greater or less extent in all forms of insanity. Griesinger says, "it is an incontestable fact that the initial period of all mental diseases is a state of melancholia," and makes exceptions only of sudden explosions of mania, and insanity following acute diseases. When melancholia is produced by moral causes it is a prolongation of them and aggravated in intensity. It becomes an exaggerated painful emotion.

We are unable to see why exceptions should be made to the above rule, in case of sudden explosions of mania, &c. The fact that there is a general upheaval does not contradict the general truth, if it be a truth.

Exceptions to this general rule are found in cases of pure ideational, or delusional insanity, and in the various forms of partial insanity usually termed monomania. Yet it is difficult to find among these a case in which there is not lesion of the sensibilities. The belief, which constitutes the delusion, is so intimately blended with feeling that we cannot separate them. The delusion is then the expression of the feeling. Where action follows in the line of the delusion the sensibilities must be involved, otherwise no action would be manifest. To be insane in thought alone, without change of feeling, is to be in a state of intellectual activity without emotion. That there are men whose thoughts, and these may be formulated into conclusions, do not excite action, no one can deny, for no creative emotion is excited. Orators can move the masses, excite emotion in others, yet never be moved by their own thoughts. A

common sot may make a temperance speech, a hypocrit, point out the path of duty. On the contrary, many can reason upon an act, yet are powerless to resist the impulse that drives them to it. The impulse creates no idea of motive or the end to be attained. Thus, one patient who would break windows declared he did not wish to but could not help it. "Something came over me—I had to do it." But it must not be inferred from this that all insane persons attempt to resist impulses to violence, or that all attempt to reason against their feelings. In the incipient stage of disease this is true, and when the main force of the attack subsides, and reason begins to assert herself, then this is more manifest than at any other period, but with many cases it runs throughout their course. However violent the form of disorder there are but a small per cent. of cases that do not retain some of the faculties undestroyed. That the conduct and action of a patient is in the main determined by his feelings is indisputable, and that his impulses govern largely his acts and thoughts is equally true, whether he can reason upon or against them or not.

Hypochondriasis is melancholia, and the only line of demarcation is, that the attention is fixed upon physical states, and may not be so wholly incapable of receiving impressions, or acting upon subjects not pertaining to these conditions. The states of depression resemble those which might exist if the condition imagined were real. They act from the stand point of their belief. Thus one young lady would never make any physical exertion for fear her heart would stop. She had been told she had heart disease and believed it, although none existed. With hypochondriasis the idea may move from one organ to another. One day the subject may fear he will die of Bright's disease, and the next day of brain disease. To question such person concerning any organ is to fix his attention upon it, and immediately he believes that something wrong exists. A successful merchant in Ohio abandoned the study of medicine because he was tormented with the belief that he had every disease he read about.

The fully developed disease, when well marked, need never be mistaken. It is only in cases of mixed form, where rapid changes occur, or where the patient has concealed the state of feeling or belief, that trouble is experienced. In one case sent from Danville, Illinois, to a State Asylum, a lady who believed herself lost, that she was too wicked to live, &c., concealed these ideas for several months, until the authorities pronounced her well and discharged her. Being consulted soon after her return, I gave it as my opinion that she still entertained the same delu-

sions as before, from many details observed, of appearance, conduct, &c. Confronting her squarely with this statement, she declared it true, and said she believed as firmly as ever that she ought to die. I advised her return to the Asylum. Her husband intended two days later to start with her, but the morning of that day she shot herself with a gun his watchfulness had not been sufficient to keep from her.

Here let me say, that with melancholics of whatever form, there is danger of suicide, and too great care cannot be exercised. None of them should be treated at home, and with forms of profound melancholia there is often greater danger when they have apparently recovered than during the graver period of disease. When in a state of torpor they have not energy sufficient to perform the act, but when reaction follows, impulses may then be powerful enough to secure the accomplishment of the purpose.

Of melancholia the symptoms are various. Burton, in his *Anatomy of Melancholy*, has gathered a mass of statements from the older writers, which include almost every possible and impossible symptom. Excluding the last, I will condense and present as briefly as possible what he has collected. In his book there is much repetition.

From Hippocrates he gathers the statement that the melancholic are lean, withered, hollow-eyed, look old, wrinkled, harsh, are much troubled with wind, and a griping in their bellies, belch often, dry bellies and hard, dejected looks, flaggy beards, ringing of ears, vertigo, light headed, little or no sleep, interrupted with terrible dreams, continual sharp and stinking belchings, as if the meat in their stomachs was putrified, or that they had eaten fish, many fantastical visions, apt to tremble, and prone to venery, palpitation of heart, cold sweat, a kind of itching, like a flea biting. There is fixed eyes, much twinkling, stuttering, headache, and a binding heaviness of the head, great veins and broad lips. He says, to some, if they be far gone, mimical gestures are familiar, laughing, grinning, fleeing, murmuring, talking to themselves, with strange mouths and faces, inarticulate voices, exclamations unpleasant to behold by reason of those continual fears, griefs and vexations; dull, heavy, lazy, restless, unapt to go about any business; yet their memories are most part good, they have happy wits and excellent apprehensions. Their hot and dry brains make them so they cannot sleep—mighty, often watchings, sometimes waking for a month or year together. One waked 50 days, one 2 years, and all without offence. They covet to eat but cannot digest, yet are lean and ill-looking. Their pulse is rare and slow, except of carotids, which beat

strong, but that varies according to their intended passions or perturbations—pulse not much to be respected. Urine most part pale and low colored, not much in quantity, but this in my judgment is all out as uncertain as the other. Their melancholy excrements vary much. Some sad, but not fearful; some fearful but not sad; some neither fearful or sad; some are both. (From Hippocaates, and includes cases otherwise termed expansive monomania.) From Galen he quotes:

"Many fear death, and yet in a contrary humor, make away with themselves. Some are afraid Heaven will fall on their heads; some they are damned, or shall be. With other things are enumerated: Fear of the devils, death, that they shall be so sick, ready to tremble at every object, they shall die forthwith, or that some of their dear friends are dead, imminent danger, loss or disgrace, that they are of glass, and therefore will suffer no man to come near them, cork, light as feathers, heavy as lead, that they have frogs in their belly, one dare not walk from home alone for fear he should swoon or die; one fears every one he meets will kill or rob him, one dares not walk alone for fear he should meet the devil, a thief, or be sick; fears all old women are witches, and every black dog or cat he suspects to be a devil. One dare not go on a bridge, near a pool, rock or steep hill, lie in a chamber where cross-beams are for fear he may hang, drown or throw himself down. If he hears a sermon he is in constant fear he shall speak aloud something unfit to be heard. Dare not be locked in a room for fear he shall be stifled for want of air. He will freely promise to undertake any business before hand, but when it comes to be performed, he dares not venture, but fears an infinite number of dangers. Some fear the ground will sink under them, or that the King will cause them to be executed for things they never did. They are afraid they will come to want, lose all their goods, but know not why. They fear they are suspected of crime, and will not be seen abroad. Some fear they are, or will be poisoned, whoever is seen in sickness or trouble they fear the same. Remove one fear and another soon takes its place. Suspicious, jealous, testy, pettish, peevish, snarl and growl at everything. If any ceremony or attention they expect is omitted or overlooked they are insulted. If two talk together it is about them, or if one laughs. They are inconstant, passionate, impatient, what they want they have no patience to wait for. Humorous, laughing, or crying without cause, bashful, can scarcely be compelled to do that which concerns them. Had rather write than speak, not free with strangers and difficult to get acquainted with."

The intellectual lesion is generally manifested concerning self. The perceptions, conceptions, ideas and acts all are colored by this. We will make one more extract from Burton, using as near as can be done his own language :

"They are soon tired with all things ; they will now tarry, now be gone ; now in bed they will rise, now up, then they will go to bed ; now pleased and again displeased ; now they like, by and by they dislike all and weary of all. Discontented, disquieted upon every occasion or no occasion, often tempted to make away with themselves ; they cannot die, they will not live ; they complain, weep, lament, and think they live a most miserable life ; never was any man so bad. Every poor man they see is most fortunate in respect of them ; every beggar that comes to the door is happier than they are. Jealousy and suspicion are common symptoms of this misanthropic variety."

Much of this lengthy detail of symptoms you readily recognize as peculiar to hypochondriasis, that is an excessively delusional melancholia.*

Another form of melancholia is the delirium of persecution.† In many cases of melancholia there are ideas fixed which are but the perpetuation of the moral cause inducing the condition. Thus, when induced by a specific cause, this is ever present in the mind, as in nostalgia, love-sick melancholia, &c.

The subject of melancholia usually sits with his hands crossed, or with the arms hanging by the side, or may stand for hours in one place. The eye and ear are constantly open, if delusion of danger or fear predominate. Many would starve if not fed, although they may be hungry.

The pulse is generally slow, feeble, concentrated, sometimes very hard. The skin is dry, sometimes burning hot ; again, it may be cold, damp, even clammy and sticky. The bowels are usually constipated. Sometimes great accumulations in the colon. This is considered by some as a cause of the disease, but is an effect, as much as any other symptom of nervous exhaustion. Melancholia with stupor, melancholia attonita, we will discuss under the head of dementia.

Religious melancholia begins generally with hallucinations of sight or hearing, which the patient attributes to supernatural origin, visions,

* In a lecture of this course to be published in the July Number, 1883, of the *Alienist and Neurologist*, upon "Sensation, Perception, Consciousness, Normal and Abnormal," many points seemingly omitted in these lectures are presented, also in the succeeding ones in this JOURNAL, especially in No. 6 and 7.

† At the time of preparing this for press there are three cases of this form of mental disorder in the Retreat.

spiritual apparitions, &c. Sometimes he thinks he is God, the equal of God, or His representative. He has exstatic transports, believes himself a demon, or charged to execute God's will, and in obedience to it will kill those most dear to him. When homicidal delusions, or impulses, exist in melancholia, they usually resemble those of puerperal mania, or the emotional state following drunkenness. If they believe their wrongs result from tyranny or oppression they may attempt to destroy rulers, or public men, they may attempt to right the wrongs of others. They believe God will not permit them to be punished for what He, in their belief, has ordered. One man hung in this State, who believed he was the equal of God, maintained to the last, even upon the scaffold, that God would not let them hang His equal. They may feel compunctions of conscience and fight it off as long as they can, but at last are overpowered by the delusion. The mother who kills her children that they may never sin, and be sure of heaven, or to prevent starvation, or from any delusion, often resists it for some time. There is no class of insane so dangerous as those with fixed ideas, if their delusions assume a homicidal form, for they will often plot and plan and show the highest degree of skill and cunning to enable them to do the act.

Such patients often curse their imaginary foes by the hour, may yell at them from their window, or address them as if present. That many such cases exist no sane man will dispute, and that the allegation so often made, that it is an "insanity dodge" is rather the exhibition of ignorance, passion and a thirst for blood, than a reasonable opinion. It is not our object at present to discuss the legal relations of insanity, but a certain knowledge of these relations is necessary to enable you to form a clear opinion and satisfactory diagnosis. The hatred and feeling of revenge is not always malice.

Tardieu* reports a case of a young man, 19 years of age, who killed his step mother. He had conceived a hatred nothing could justify. One morning while the family were at breakfast he entered, his gun in hand, and without saying a word, shot her dead. He then fled, and after having wandered in the country for some time delivered himself up. He acknowledged the crime, but gave no explanation. The Court could not believe him insane. The jury, however, acquitted him on the ground of melancholia.

Tardieu's official report made to the Court was.

1st.—We believe that the accused, I. R., was in a true state of mental

* Etude Medico Legale sur la Folie.

alienation the 10th of November, 1854, at the moment he committed the murder of his step mother; 2d—that he did not possess the will of a reasonable man, or his own free will, while committing the act, and that he ought not to be held responsible before the law; 3d.—that if he has ceased to be insane immediately after the murder he has not ceased to be predisposed to the different mental affections, as suicidal melancholia; 4th.—that consequently we ought to fear that he will show at some day a relapse with bad consequences.” Soon after he killed himself upon his mother’s grave, showing the correctness of Tardieu’s views.

A common mistake made with reference to the insane with delusions, is that they are allowed to manifest evil tendencies, and are left free to act. It is very foolish to defer action in a case on the ground that a man is a well-disposed man, or on the other hand that the evil tendencies are only the natural ill-humor of the man.

Many patients who have suffered from mania pass into melancholia, and are victims of depression, mortification and distress, on account of their past state. Friends often aggravate this by ill-judged remarks. At this period, when the nerve centres are exhausted by the protracted excitation of mania, they need more than ever kind care and encouragement. The shock the nerve centres have sustained may otherwise become permanent. The brain goaded on by rapid circulation, excessive excitement, in mania, may become exhausted and melancholia, or dementia, follow. In melancholia the brain partakes of the general physical depression, and in profound cases is little more than an inert mass. The languid blood stream, the want of nutrition, and all agencies combining to withdraw a stimulus, it is inactive. In mania, thoughts come crowding on; and just as with a crowd of men passing along the street, now and then one may be recognized, but all seem a confused mass, so the mind is all confusion, and little that passes through it is recognized. In melancholia, the slow train of fixed ideas ever passing in review makes familiar their faces.

To conclude: If the invasion is sudden, it is usually due to some immediate moral influence, which gives shape and character to the delusions. They reflect the cause. If premonitory of mania it gradually assumes that form of disorder—melancholics are subject to periods of mirth and hilarity, which may extend to furor. Do not conclude that it is a case of mania because the patient is agitated at times, walks and talks, or laughs and appears gay. Some of these cases are intensely suicidal. Often when in a crowd they are brilliant in conversation and seem gay,

but sink into gloom and darkness as soon as they are alone. You may have melancholia with or without delusions. The physical functions are more disturbed than in mania, the physiognomy reflects the inward storm of torture, anxiety, envy, hatred, jealousy, suspicion, fear and despair. *Remember they are suicidal.*

THE TREATMENT OF PUERPERAL FEVER.

From Discussion before the Montgomery Co. Medical Society.

BY J. C. REEVE, M. D., DAYTON, OHIO.

THE treatment of puerperal fever having been assigned to me as my share of this evening's proceedings, I will begin with the statement, that it resembles very much in many respects the pathology of the disease. As this has been shown to-night to have, in recent times, made great advance, so treatment has of late changed in many respects from what it was a few decades ago, and we believe for the better. As it has been shown that under the term puerperal fever are included affections differing very considerably in leading features, so treatment cannot be simple, but must be adapted to the varying manifestations of diseased action, and as much remains yet unknown and uncertain in pathology, so we have to regret a lack of precise and reliable remedies for the control of the disease.

As the time left to us is now very limited, I can but consider this branch of the subject very cursorily and perhaps in a more dogmatic tone than becomes the discussion of a scientific subject.

The first proposition I would lay down is, that the fact of fever in the puerperal state calls for the immediate administration of full antiperiodic doses of quinine. To this statement I would admit no qualifications and recognize no exceptions. In this region we have daily and hourly evidence of the all-pervading influence of malaria, complicating and modifying all forms of disease. We are all familiar with the fact that after any powerful perturbation of the system, a fracture or any severe injury, the malarial influence under which we all live manifests itself by an outbreak of chill followed by fever more or less remittent in character. Labor is frequently the disturbing element, the perturbation, which bring on such outbreaks of malarial fever. Malarial puerperal fever is a recognized form

of this multiform disease. At the onset of fever, then, in the puerperal condition, before time enough has elapsed to determine its exact character give full anti-periodic doses of quinine. While some special symptoms, as headache, more pronounced backache and aching or soreness of the limbs, will allow a probable diagnosis of the malarial form of the disease, still, if it proves not to be that, no harm has been done by the remedy, while if it is malarial the case is speedily controlled.

The next proposition is that local measures of treatment are of the first importance, should be immediately instituted, and be thorough in character. While to this proposition exceptions may be allowed, they are but few in number and in general it will stand as true. It is based upon the now accepted pathology of the disease, upon the septic origin and nature of these varied inflammations of the pelvic and abdominal organs, when the disease is localized, upon its essential identity with surgical septicemia and pyemia when it is general. By local measures of treatment is meant such cleansing processes of the genital canal, from the fundus uteri downwards to the vulva, as shall remove all matters, fluid or solid, which are undergoing decomposition, wash the surface of all sloughing wounds or ragged lacerations and thus prevent further absorption of septic materials, organized or unorganized. Whether bacteria, micrococci or chemical ferment, makes no difference. From a certain amount of absorbed poison it seems clear that the system can recuperate, or, in other terms, it seems clear from clinical experience that absorption is often continuous or repeated and that by removing the source from which it occurs great and immediate benefit results. "Let no one suppose that septicemia once established becomes irremediable. Experience disproves this; it is the prolongation of exposure to absorption of septic elements that constitutes the great danger of the condition."* The good effect of this measure is frequently shown by a decided fall of temperature, instances of which are given by every recent authority. We have the same thing after ovariectomy from washing out the peritoneal cavity as first done by Peaslee and which was such a marked advance in therapeutics.

Antiseptic and disinfectant injections are, then, always indicated and always necessary. They should be intra-uterine, therefore should be administered by the physician himself. Antiseptic vaginal injections are advisable after every labor, and I always order them where there is a nurse. Whenever the lochia are offensive they are imperatively necessary as a prophylactic measure. Whenever there is puerperal

*THOMAS: *Diseases of Women*, p. 750.

fever, intra-uterine injections are indispensable. The uterus should be washed out with a solution of carbolic acid, or what I prefer, of permanganate of potash. A catheter, or some sort of pipe, should be carried to the fundus and the stream should be, preferably, continuous rather than by intermittent gushes. It requires no other apparatus than that always at command, although many different instruments have been devised. The open condition of the os obviates the dangers which often attend intra-uterine injections. They should be repeated twice or three times in the twenty-four hours.

This measure of treatment is the direct and necessary outcome of the recognition of the origin of the disease in septic absorption, whether autogenetic or heterogenetic, which began with the observation by Semelweis, of Vienna, in 1847, of the frequency with which puerperal fever occurred in patients attended by students who were dissecting. It is one of the greatest advances of recent times and has the most solid foundation in both pathology and clinical experience. The times change and we change with them. It is but little over ten years ago that I had under my care the wife of a prominent citizen with puerperal fever. I used intra-uterine injections, then the subject of articles in journals but not yet in the text books. A consultation was held, and they were strongly opposed by the consultant. After the unfortunate termination of the case I learned that I was severely censured by some members of the family for this measure of treatment and that the censure was sustained by the opinion of the consultant. Now there is not a text book, nor an authority, to my knowledge, that does not advise their administration. Understand me—in one or two books there are cautions against, or condemnations of, prophylactic intra-uterine injections, but that is another matter.

In some cases of puerperal septicemia or pyemia even more decided local measures than injections are demanded. Wherever there is a suspicion that solid matters, as portions of the placenta or membranes are retained, the curette should be used. It need scarcely be added that if the presence of such matters is sensible to the touch the use of the instrument is imperative. By careful and judicious use of it no possible harm can be done and very much and decided good may result. I need but allude to a case seen by several of you within a few months where puerperal septicemia had been combatted by injections as well as by other measures for many days, and where marked improvement followed so closely upon removal of a quantity of solid and fetid particles with the curette that no doubt could be entertained as to the cause and effect. This was a case of full-term delivery, but it is after abortion that the instrument finds its most

frequent necessity. But quite recently I used it and removed large pieces of retained and stinking placenta from a case of abortion about the third month. The case unfortunately terminated fatally. It is needless to say that this is not a remedy for repeated application, once done and done thoroughly is enough.

The case having fully developed into one of puerperal septicemia, what are the remedies to be addressed to this condition? Have we any capable of destroying the septic poison which has been absorbed or of obviating its effects? Unfortunately this question must be answered in the negative. From time to time such remedies have been recommended and some of them with great confidence, even with enthusiasm, but none have yet established themselves in the confidence of the profession. Salicylates, sulphites and carbolates have alike proved unreliable. (There is one medicine which has good theoretical grounds in its favor, and that is the muriated tincture of iron. The close relationship of puerperal fever to erysipelas justifies the administration of this in full doses, and clinical experience has shown nothing against its use.) The treatment is, then, the same as for surgical fever which is synonymous with surgical septicemia; due support of the patient by liquid and easily digested aliment, the judicious administration of alcoholic stimulants, and one or two doses of quinine in the twenty-four hours.

For those cases in which the local manifestations of disease predominate, as well as for some of the more general, the treatment must be in great measure symptomatic, and in reference to this, certain symptoms and the remedies for them, demand consideration. Pain, if pronounced and severe, calls for opium; so does marked peritonitis. As with idiopathic peritonitis it is our sheet-anchor, and as it is always essential that pain be annulled as soon and as completely as possible, this remedy should be administered with a free hand whenever it is indicated.

It is in these cases where pain and tenderness of the abdomen are prominent that warm local applications are undoubtedly beneficial. There is very high authority against them, I am aware, but if well managed they are a comfort to the patient, if of little curative value, and the use of them is in accordance with popular notions and prejudices. Turpentine stupes may be said to be more generally used than any other form of application and they combine counter-irritation with fomentation. Large light flaxseed poultices are good and without the odor of the turpentine, so disagreeable to delicate patients.

The great leading feature of the disease is of course the fever, and although the range of the temperature in septicemic forms is exceedingly irregular, the excursions being sharp and pronounced, in proportion to its

general elevation will be the danger to the patient. Whenever then the thermometer runs up to 105° or above, this symptom requires special treatment. Early in the disease, before the patient's strength has been drawn upon seriously, the administration of aconite in small and frequently-repeated doses will prove beneficial. I prefer it, theoretically, to veratum viride notwithstanding the high favor shown the latter by our only authority on puerperal diseases, while practically it is preferable especially on patients not within easy reach of the physician, because it does not produce that distressing and depressing nausea which veratum does when pushed a little too far. The salicylates may here be used as a febrifuge and have testimony in their favor which they have not as antidotes to or neutralizers of the absorbed poison.

The power of quinine to depress the temperature is well known and generally resorted to. To produce this effect, however, the doses must be massive—not less than a gram, and from that to twice the quantity. There are decided unpleasant effects connected with this mode of administration of the medicine, especially in patients of great nervous susceptibility. Moreover, while the depression of temperature by such doses is marked it is never of very long duration, nor do I know of any case or cases reported where this plan of treatment has produced marked and continued improvement, or effected a cure. I confess, therefore, that it is not a favorite one with me, nor one to which I would resort unless under exceptional circumstances.

The constant application of cold, as taught by the modern German school, is one of the most efficient and reliable means of reducing temperature in disease, and the results obtained by Liebermeister and others in the treatment of typhoid fever have been the means of extending the application of this remedy to other affections and notably to the septicemia and pyemia of gynecology and obstetrics. Unfortunately, here popular prejudice stands in our way. I have known of no instance in private practice where cold baths or cold applications have been applied to a lying-in woman, or where they have been proposed. I should expect to meet with very decided opposition to their use and to receive certain and severe condemnation in case of an unfortunate termination of the case. Nevertheless the results obtained by the Germans, as Schroeder and Spiegelberg, have been such as to encourage us to resort to the remedy. The latter gives as indications for the use of cold baths, a continued high range of temperature, the erratic chills of phlebotic septicemia, and whenever the evil results of continued high fever are to be found. As

contra-indications he recognizes acute sepsis when collapse is threatened and the presence of thoracic complications.*

It is evident that without any prejudices to oppose cold baths, the circumstances of the great majority of families would restrict a resort to them to exceedingly narrow limits.

There is another mode of application of cold which seems applicable to a much wider range of cases and which has yielded such excellent results in cases analogous to puerperal fever that it deserves our earnest attention. I allude to the use of Kibbee's fever cot, as adopted by Dr. Thomas, and used with excellent results for the treatment of septicemia after ovariectomy. You probably all well know his description of the apparatus. It is a simple cot with woven-wire or cotton-netting bottom, under which is placed an India rubber cloth in such a way as to carry off the fluid to a convenient receptacle. On the wire-netting a blanket is folded and upon this the patient is laid. Her upper garments are drawn up to the armpits, her lower extremities are covered with flannel drawers to the pelvis and bottles of hot water are placed at her feet. Then the abdomen is enveloped in a folded sheet and to this the application of water is made. A large pitcherful at from 70° to 80° Fahr. is poured gently on the sheet, and a couple of blankets are thrown over the patient. The water runs down through the netting and is found to have gained from 8° to 10° of temperature, and by continuance of the process the temperature of the patient can be brought down to 100° . When it ascends again another application of cold water is made and so the treatment is continued. Dr. Thomas says he had tried every means of using cold to combat fever and had about given up all hope of being able to use the remedy until this cot came under his notice. He has employed it freely for more than a year, has kept patients on it for two and three weeks at a time, and increasing experience with it increases his estimate of its value. It seems to be one of our most efficient means of combatting hyperpyrexia and might be put in force almost anywhere in private practice.

A brief and general sketch of the treatment of puerperal fever cannot be expected to cover every point. Such a sketch this was intended for, suitable to close an evening's discussion. Perhaps I ought to say a word as to cathartics. I believe they are of but little value and rarely indicated in this disease. Premising that the bowels have been tolerably well emptied early in the disease, spontaneously or by medicine, I doubt much the benefit to be derived from cathartics, although I may possibly upon this point differ from some whose opinion is equal to as much and

*Lehrbuch der Geburtshilfe, 1878.

even far more consideration than mine. That the diarrhea of septicemia is eliminative in character and therefore should be favored, I believe to be a delusion. If cathartics are given they should be mild and unirritating in character. Spiegelberg speaks in strong terms against the use of calomel as a purge, and says that he has always seen an increase of the peritonitic symptoms follow its use, and sometimes have seen these arise in consequence of it.

THE RELATION OF PUERPERAL FEVER TO THE ZYMOTIC DISEASES.

BY C. H. HUMPHREYS, M. D. DAYTON, O.

Abstracted from Discussion in Montgomery Co. Medical Society.

Since Gaspard, three quarters of a century ago, began experimental inquiries into the causes of puerperal fever, the medical mind has been continuously busy endeavoring to determine the real nature of the disease. It is inexpedient, in these limited remarks, to even attempt an historical sketch of the development of this question about which volumes have been written. As practicing physicians, we are given to admit as worthy of consideration clinical results only.

From the earliest times has existed the belief that there is a close relationship between puerperal fever and erysipelas, and facts to support such belief are not wanting. The histories of the two diseases show that they prevail usually simultaneously when they appear as epidemics.

About thirty years ago, this and other portions of our country were visited by epidemic erysipelas, and during its prevalence nearly every parturient woman was attacked with puerperal fever. And according to Trousseau, infantile erysipelas is principally observed in Paris when puerperal fever prevails in the lying-in hospitals.

There is also strong evidence to show that the contagium of erysipelas may be communicated directly or by a third party to a parturient patient inducing in her puerperal fever. But while the contagiousness of

these two diseases is not refuted, the tendency of the medical mind at present is against its belief in the strict acceptation of the term. It is not doubted that it is inoculable. It is accepted that communicable zymotic diseases depend on a material organic poison. The manner of the absorption of this poison probably has much to do with its intensity. Introduction through the wounded generative tract possibly may cause it to show itself as a septic poison producing the condition called puerperal fever. It was long ago observed that "when epidemic erysipelas prevailed, while it produced in some an erysipelatous affection of the skin, in others it gave rise to inflammation of internal organs, frequently the peritoneum in either sex.

Though they may be modified, it is not believed the essential fevers lose their individuality when they attack the lying-in woman. If she be attacked, their depressing influence may tend to the development of inflammatory action in parts already taxed and exposed by the parturient act and overshadow the original fever. A tendency to putrefactive changes in some of the tissues exists as a natural sequence of some of the zymotic diseases. Examples of which are, the decomposing membrane of diphtheria and the angina of scarlatina. We know every recently delivered woman presents abrasions and lesions, due to her labor, affording easy access to her system of septic poison.

It is hence readily seen why puerperal septicemia may follow exposure to zymotic influences—it is not due to the absorption of the specific germs producing zymotic diseases, but to the putrefactive germs developed in consequence, proof of which is the frequency of sporadic puerperal fever and the fact that specific zymotic diseases do not originate *de novo*.

In reviewing a report* of 89 cases in consultation (private) practice, by Braxton Hicks, I find that 52 of the number, where there was an ascertained cause, were due to zymotic influence; 37 to scarlet fever, 20 of which were accompanied with the usual rash, the balance without; 7 to diphtheria; 6 to erysipelas; and 2 to typhus or typhoid fever. Dr. Hicks thinks scarlatina, as a source of the mischief, may have existed in even a larger number, inasmuch as it is prone to be masked and take an irregular course in the puerperal state; or even, owing to its intensity, produce death during its period of incubation, just as erysipelas may act fatally under such circumstances without the usual skin affection.

He also observed that puerperal scarlet fever usually appeared on the third day, which coincides with the ordinary development of puerperal

*Report of London Obstetrical Society, vol. XII, 1870.

Vol. I.
No. 11. —.4

septicemia, the rash a day later ; that very often the patient resisted scarlet fever during gestation only to be seized at delivery ; and that generally it gave rise to such complications as metritis, cellulitis and peritonitis. It would hence appear that the disease was communicated by inoculation, increasing its virulence.

Mr. Paget has observed that after operations and accidents, erysipelas, scarlatina and measles are most apt to appear like a local disease, first at the seat of injury, and then to be more intense. The small number of cases due to erysipelas is noticeable, and its explanation may be due to the relative infrequency of sporadic erysipelas compared to the wider prevalence of scarlatina, and also to the fact that scarlatina effects principally children—a class of patients intimately associated with pregnant women.

Malaria as an ascertained cause was not observed in Dr. Hick's cases. In this country puerperal malarial fever is distinctly recognized.

The influence of other zymotic diseases may be less marked but is seriously felt during their prevalence.

Dr. Hicks concludes that puerperal disturbances are usually produced by zymotic influences, and that the prevention of the contagion of scarlet fever alone would reduce the number of cases at least one half.

A CLINICAL LECTURE ON NERVOUS AFFECTIONS OF THE SKIN.

*Delivered to the Medical Class of Wooster University, Cleveland, Ohio,
March 26th; 1883.*

BY WM. T. CORLETT, M. D., L. R. C. P. (LOND.), CLEVELAND, OHIO.

[Reported for the Columbus Medical Journal by Mr. F. F. Lawrence.]

GENTLEMEN: To-day I wish to call your attention to a class of skin affections which are the local phenomena of either functional or structural disturbances of the nervous system. To this abnormal, or disturbed innervation we give the name *Neuroses Cutanea*.

In my opening lectures, when speaking of the histology of the skin, you will remember the three kinds of nerves then described which are

distributed to the integument, viz: the motor, sensory and vaso-motor or sympathetic nerves; later, when speaking of the pathology and symptomatology of cutaneous affections in general, I called your attention to the important role the sensory and vaso-motor nerves play in the phenomena of cutaneous inflammation, and, since most cutaneous lesions which give type to disease are the products of inflammation, the question arises as to what inflammations are to be classed under the head of neurotic affections. Here, gentlemen, in this borderland, lies the difficulty. In this little girl you see a case in question. She is 5 years old. Her present illness is attributed to vaccination when 3 months old. The disease has continued in an uninterrupted course until the case came under my care in June last. My notes of the case at that time are as follows:

June 1, 1882—M. N., aged 4½ years, female, has an eruption accompanied by severe itching. In appearance the patient is of normal size, with light hair; bridge of nose deeply sunken; dull, inanimate expression of eye, with divergent strabismus of left; teeth well formed; for her age does not possess an average amount of intelligence; walks with a clumsy, awkward gait, often stumbles; has incontinence of urine; is anemic, but has good appetite; bowels regular; urine normal. Has moist eruption, with yellowish crusts, over extensor aspects of the body, especially over the regions usually occupied by psoriasis. Flexor surfaces of joints free, as are also head, face, hands and feet. Itching intense. Concerning the family history there is no evidence of syphilis, notwithstanding the physiognomy of our little patient. She has brothers and sisters enjoying the most robust health, but the father is suffering from a skin disease which I regard as a neurotic affection. I will have the pleasure of showing the case at this clinic.

I at first regarded the malady we now see, Eczema, as having an etiology of a local nature; first carried from an active vaccine pustule, and aggravated by the local irritation of bed clothing saturated with urine. The treatment employed—after regulating the diet and restricting the use of soap, substituting therefor bran—consisted, first, in preventing local irritation, and then the internal administration of arsenious acid (gr. 1-60, t. i. d.), alternated with calcium sulphide, in 1-10 grain doses. As an application, the compound thymol ointment was used. This line of treatment, with slight variations, was continued until July 17th, when the eruption had entirely disappeared. This immunity lasted until November 20th, when the patient returned with the eruption in character similar to that of the previous attack, but in position confined to the regions sup-

plied by branches of the *anterior crural*, the *external cutaneous* and *communicans peronei* nerves. At this time the incontinence of urine, under treatment, had ceased. The former treatment was again commenced, but without the former happy result. Of late I have given the quinine sulphate and strychnine sulphate in tonic doses, and the eruption, which is still well defined on the left extremity only, is slowly disappearing.

I next present to you the father of the little girl you have just seen; he is 37 years of age, and you see is a man of apparent health, of temperate habits, save in the use of tobacco; of medium height, with a bright, active expression; dark hair and blue irides; he is suffering from an eruption of the hands, which we call *Hydroa*, giving rise to extreme annoyance. It first appeared twelve years ago. He denies ever having syphilis, rheumatism, or any other illness, excepting an eruption called "*prickly itch*," involving the whole cutaneous surface, which lasted three years, and, as the patient says: "Settled in his hands," and here it has remained, at times disappearing, only to return upon the slightest change of weather or any depressing effect upon his mind. Sharp, shooting pains extending along the radial and ulnar nerves precede the attack; that is followed in a day or two by an eruption of vesicles, the contents of which, at first serous, soon becomes, as you see now, purulent. These pustules are wont to remain for a varying period, and are followed by free desquamation. This never invaded the palms. A few vesicles have appeared on the dorsal surface of the feet, but at present they are free. The family history reveals some points of interest. You will find in all neurotic conditions, not confined to dermatology alone, a tendency to transmission. His mother, he says, had an eruption upon her hands most of her life.

The diseases most liable to be confounded with this would be, first, scabies, which you would exclude by the absence of cuniculi, besides the clinical history of scabies, as you remember, is different, in that it has no such neuralgic prodromata. The treatment will be quinine sulphate, gr. j, t. i. d., and to relieve the smarting and tingling,—which in this class of affections takes the place of itching,—a 15 per cent. solution of carbolic acid.

We next have this boy, who is 17 years old, and is employed in an iron foundry. You see this eruption following a somewhat serpentine

course over to the posterior aspect of the right shoulder and down the arm and forearm. It is *Herpes Zoster*. It may follow the course of any sensory nerve, most frequently the intercostal of one side. The supraorbital is also a frequent site, but in this lad it follows the distribution of the 3d and 4th cervical, as well as that of the external cutaneous nerve. The patient's account of the affair is substantially this: Five days ago he went to a ball; becoming heated he cooled off by sitting in an open window with his right arm outside; the resulting vaso-motor disturbance, which in most of us would have been located in the schneiderian membrane, affects in this case either the central ganglia or the course of certain nerves, and is shown by pain along the distribution of the same; this pain lasted a few days and was succeeded by an erythema, which in its turn was followed by vesicles upon an elevated erythematous base. This nervous susceptibility may be inherited from his mother, whom I will next show you. The only treatment indicated here is to protect the inflamed region from external irritation by means of flexible collodion.

This is the lad's mother. First study her physiognomy carefully. She is 45 years of age; a native of Ireland; has been a resident of this city 34 years. You notice her pale face and restless, vacant expression. Those of you who will take the trouble to visit the Hospital for Insane, at Newburgh, will understand better the meaning of this expression of "*nervousness*," as the patient herself terms it.

She consults us for this eruption, which you see coursing along over the left temple, extending to the external canthus. In character it consists of elevated, erythematous spots, in size that of a split pea, covered with a few dry scales. When a spot is taken between the thumb and finger, we detect a perceptible thickening. We might with propriety call it a tubercular eruption, apparently following a serpentine course, gradually becoming less marked as it proceeds forward from a point just above the left ear to its disappearance near the orbit. There has been no discharge. The burning and tingling give great discomfort. This condition, she says, has existed six months. Her previous condition, too, has not been entirely a happy one, she having had a goodly number of those ills that flesh is heir to, for she tells us she once had the "shakes," also used to "get blind suddenly," at other times "would fall down suddenly, but when taken into the open air would get better." The family history reveals her

mother afflicted with an eruption upon her legs and feet, lasting several years, coming on late in life.

The treatment I have found most useful in this class of affections, especially where malaria is liable to be a factor in the case, as evidenced in this case, by the "shakes," is quinine. Locally we will give the following:

R Chloralis,
Camphoræ,..... aa ʒij;
Unguenti hydrargyri nitratis, ʒi.—M.

Sig. Apply twice daily.

In this arena of human woe, even our own profession does not escape. Here is my friend D.— who has a periodical eruption on his left hand, which has troubled him fifteen years. You see it is circumscribed, always occupying the same position—the ulnar half, dorsal aspect, of hand extending forward to the base of the little finger. Its chief points of interest are a crop of vesicles appearing with the first cold spell of autumn, followed in a week or so with a scanty desquamation accompanied by itching, which appears daily at 4 P. M., the symptom disappearing in the following spring. Here, too, is an instructive feature; his mother and other members of his ancestry have had a similar condition of one hand. We have subjected scrapings to careful microscopical examination without finding any special parasites. The Doctor has carefully protected this hand against possible irritation, even of cold, by constantly wearing a heavy fur glove, without benefit, but a trip to Florida will cause it to disappear.

These cases you have seen to-day would roughly be called *Eczema*; possibly they are, but we have certainly an etiological factor here not found in our ideal *Eczema*.

MEDICINE.

ON THE PATHOLOGY OF DIABETES; ESPECIALLY DEALING WITH DIABETIC COMA.—Dr. Stephen Mackenzie, Physician to, and Lecturer on Medicine at, the London Hospital in a paper bearing this title, and originally read before the British Medical Association at Worcester in 1882, gives a total of thirty-seven fatal cases of diabetes in the London Hospital from the beginning of 1874, to Midsummer 1882. “From this series of cases, twenty-one of which have been under Dr. Mackenzie’s own care, it appears that coma and phthisis are the two most common modes of termination of diabetes. Coma is a much more common ending of diabetes than is often supposed by those who see but few cases of the disease. In this series, coma of a peculiar kind was the termination of diabetes in nineteen out of thirty-seven cases, or in just over half the number. Of these nineteen cases of coma, in seven *post mortem* examination showed no gross visceral disease to which the coma could be attributed; in four cases without *post mortem* examinations, there was no *ante mortem* evidence of visceral disease in three, and in one there were well marked signs of pneumonic phthisis during life. Further, there were eight deaths from coma, with old or recent pulmonary disease found at the necropsy; in some of these the affection of the lung was insignificant, in others advanced. The coma that closed the scene in the cases of diabetes, implicated (or followed) by pulmonary disease, had certain special characters, to be presently described, showing its connection with the diabetic rather than with phthisis. It was not the mere loss of consciousness that terminates so many exhausting diseases. Suddenly developing coma is an unusual ending of ordinary phthisis. Besides in these nineteen cases, in three others death was by coma, but an obvious explanation was presented on *post mortem* examination—viz., cerebral hemorrhage, meningitis, suppurative nephritis. *Onset*.—Pain in the epigastrium or hypochondria, often very severe, sometimes ushers in the attack, and may precede for several days the coma. Delirium, usually of a light garrulous kind, is observed in some cases. Rapidity of pulse is occasionally the first indication of impending coma. Vomiting and diarrhea, separately or together, were noticed in some cases for a day or two before the attack. Severe headache precedes the coma in others. Fatigue, as pointed out by Prout, and noticed by nearly all who have written on the subject, often determines coma, and the latter is thus frequently induced by a journey. *Special Features of the Coma*.—One of the most striking symptoms in most though its degree varies in different cases, is a peculiar laborious breath

ing—an “air-hunger,” extraordinary efforts of filling the chest being made. The patient lies gasping for breath, like a person after violent exercise, whilst no condition in the respiratory organs accounts for its occurrence. Sometimes, this dyspnea precedes the coma, sometimes the dyspnea and coma appear together. The coma in most cases commences gradually. The patient can at first be roused, but it steadily progresses until it is profound. It occasionally commences more abruptly, and in a few cases passes off, usually to return. The surface of the body is generally cold, and the skin and mucous membranes livid; the pulse is rapid and small, and ultimately becomes uncountable. The external and internal temperature sinks exceedingly low, and Dr. Mackenzie has known the temperature in the rectum to be little over 90° Fahr. This combination of coldness, lividity, and rapid pulse has led me for some time to call the condition “coma-collapse.” Incontinence of urine is noticed in some patients. The breath has been noticed by some good observers to have a peculiar odor, like sour beer, vinegar, acetic ether, acetone, etc.; but in no case that Dr. Mackenzie has observed has this been detected, though he has been on the outlook for it since 1874, and have directed the attention of those watching the patient to the point. Dr. Frederick Taylor’s experience is similar. It has been said that a high temperature is necessary for its occurrence, owing to the low volatility of acetone. The urine is also said sometimes to give off a similar odor, but the author has not noticed it even when evaporated. In some cases, the addition of a solution of perchloride of iron to the urine produces a deep brown color. This, which is a test for acetone, Dr. Mackenzie has noticed in some cases.”—*British Medical Journal*.

PNEUMONIA IN CHILDREN.—The *Med. Press and Circular* says that: M. Jules Simon gives the following distinctive characters of pneumonia and pleurisy in children: Pneumonia commences by a rigor, by vomiting, convulsions, and a violent fever. There is no pain in the side; the respiration is quickened, sometimes reaching 60 in the minute. There is a sort of tickling sensation in the throat, which makes the little patient cough incessantly, a little dry cough. During the first forty-eight hours the physical signs furnished by auscultation and percussion are *nil*, or nearly so. The only thing auscultation discovers in the first two days, is the absence of the respiratory murmur, and apnea more or less pronounced. In pleurisy, on the other hand, there is no violent fever, no vomiting, no convulsions; so that often acute pleurisy remains entirely

unsuspected by the parents. They take the malady for a simple cold, and at the end of seven or eight days the child is taken up. It is thus parents bring their children to the consulting room, little imagining the existence of a pleural effusion. However, there is a sign that is not observed in pneumonia, and that is, pain which is not situated beneath the breast, as in the adult, but from some inexplicable cause, in the flank of the side affected.

It is not an intercostal neuralgia, as in the pleurisy of the adult, a pain radiating in some of the nerve filaments of the abdominal wall. In the child attacked with pleurisy there is but slight fever; he sleeps badly, the appetite is diminished, and he complains of a pain in the abdomen, a pain which should immediately direct the attention of the medical man to the probability of the existence of pleurisy. The respiration is but very slightly accelerated, and the cough a little dry, does not present any particular features. Twelve or twenty-four hours afterwards, percussion will reveal the existence of dullness, and a certain *bruit de frottement* will be heard by auscultation. The apnea will be observed to be more or less complete, and when the child cries a veritable broncho-egophony will be perceived. The general condition of the child is so little changed that in most cases he can get up and go about as usual. As to the treatment of this last affection, M. Simon recommends dry cupping at the beginning and poulitices. The next day or the following small blisters, left on for three or four hours and, when taken off, another poultice applied and left on for an hour, when the blisters will have arisen and can be dressed. This revulsive treatment should be continued throughout the whole duration of the disease. As mixture he prescribes the following: Tinct. scillæ, tinct. digitalis, of each ten drops; syrup, one ounce; gum water, three ounces. A teaspoonful every two hours. The digitalis and the squills should be suppressed after four or five days. Milk should be freely given, as it acts as a good diuretic.—*Peoria Med. Mo.*

OUR DRINKING WATER.—Dr. N. B. Sizer (Proceedings County of Kings, March, 1882,) formulates our present scientific knowledge of water thus:

1. No water unfit for washing in is fit to drink.
2. All soft water possessing a visible color, taste or odor is probably unsafe, but can be made potable by bringing it up to 100° C. (212° F.) and keeping it there for five minutes.
3. Rain water is the easiest accessible source of soft water; when caught

in a proper cistern, from a clean roof, especially during the last half of a long rain, when both air and roof have been washed clean, it makes a very clear and sparkling water, and is always better after filtering through charcoal, being then healthful.

4. Hard waters are apt to act as a cathartic on those used to pure water, because they are generally dilute solutions, such as we use for that purpose medicinally.

5. Organic impurity is often the source of very fatal epidemics, and is by many believed to be one of the great sources of contagion in typhoid fever and cholera.

Remember, that three-tenth grains of organic matter per gallon (1-2000 of one per cent.), has been known to do harm.

A tolerably accurate test, and useful if organic matter is suspected, is as follows :

Sol. A.—Take 200 c. c. of the water, add two or three drops sulphuric acid,

Sol. B.—Prepare a solution of permanganate of potassium of the strength of thirty-two centigrams per litre ($2\frac{2}{3}$ grains in one pint) of distilled water. Thoroughly mix three drops of Sol. B in Sol. A and note time. If Sol. A is bleached in less than ten minutes, organic matter is probably present in sufficient quantity to do harm.—*Detroit Lancet*.

FRECKLES CAN BE REMOVED, according to Dr. J. V. Shoemaker, by the careful application of a little ointment of the oleate of copper at bedtime. He makes the ointment by dissolving the oleate of copper in sufficient oleo-palmitic acid to make a mass.

THE CONTAGION OF MEASLES.—Dr. A. Beclere has made a careful study of the conditions attending the contagion of measles, of which we select his more important conclusions.

Rubeola is contagious from the commencement of the period of invasion to the end of the stage of eruption, a period extending through from eight to ten days. The contagious principle is contained in the secretion of the respiratory mucous membrane, and it still remains to be proved, that it has anything to do with the cutaneous desquamation. Although this contagion is diffusible, it is so only to a slight extent, and soon loses its active properties, and does not remain in the rooms occupied by the sick. The period of incubation lasts from thirteen to fifteen days; no immunity is conferred by the presence of any other eruptive disease.—*Gaz. Med. de Paris* ; *Phil. Med. News*.

THE FREQUENT REPETITION OF DOSES.—Dr. A. A. Smith, Professor of Mat. Med. in Bellevue Hosp. Med. Coll., contributes a paper on this subject to the *New York Medical Journal*, from which we take the following.

It is better, when giving croton chloral for neuralgia, to administer a grain every half hour, than in larger doses. A solution, of which a teaspoonful represents one grain, will have scarcely any bad taste.

Two grains of the salicylate of sodium every hour or half hour in a teaspoonful of water, will cure the most obstinate cases of urticaria, except those of chronic nature; and where it has been caused by full doses of co-paiba, single grain doses of the same drug every half hour will sometimes control it.

Fowler's solution, half a drop given every half hour, for six or eight doses, will often relieve vomiting after a debauch. It will also relieve the morning vomiting of drunkards, and is of decided benefit in nausea and vomiting of pregnancy.

Five or ten minim doses of the fluid extract of jaborandi, every hour or half hour will produce copious perspiration, without causing any unpleasant effects upon the heart, especially if combined with digitalis.

In supposed croup, which is usually false croup of a reflex origin, a teaspoonful of a solution of one one-hundredth of a grain of sulphate of atropine in a tumbler of water, every hour or half hour, will give relief.

If the child's face begins to flush and show signs of the physiological effects of the drug, the dose can be reduced in frequency. Give an emetic if there is anything in the stomach which may be causing the spasm, or a cathartic, if there be reason to suspect intestinal disturbance as the cause.

In nervous disturbances and undefinable and transitory disorders of children, the bromides, in doses of one or two grains every ten or fifteen minutes, will often prove of great benefit.

With children of a nervous excitable frame of mind, who are, perhaps, naturally of a sensitive, nervous temperament, who are disturbed by the slightest noise, and are unable to go to sleep before ten or eleven o'clock at night, excellent effects will be produced by chamomilla, the tincture in minim doses, every fifteen or twenty minutes. Put a teaspoonful in half a tumbler of water, and let the child drink it freely.

A single drop of the wine of ipecac, repeated every fifteen or twenty minutes, will often produce the most marked relief, both from vomiting and diarrhea.

Upon the authority of Trousseau, one-sixtieth of a grain of calomel, taken every hour for ten or twelve hours, will relieve the headache of syphilis occurring at night. I have administered it in one-fortieth-grain

doses in this manner, and have obtained the results claimed for it, but I have not yet tried it in sixtieth-grain doses. The relief was very marked by the second or third night. It is not intended to take the place of iodides which are given in such cases.

One twenty-fourth of a grain of mercury with chalk, every fifteen or twenty minutes, is of great benefit in the vomiting and non-inflammatory diarrhea of children.

Where the diarrhea is accompanied by mucous passages, indicative of a certain degree of inflammatory action, benefit will be derived from the administration of one teaspoonful of a solution of corrosive sublimate, one grain to the quart, every hour.

Put a grain of tartar emetic into one quart of water; teaspoonful dose of this solution every half hour will prove effectual for the relief of the wheezing and cough accompanying a slight bronchitis in children.

Single drop of the tincture of *nux vomica* given every ten minutes will often produce most marked relief in sick headache not of a neurotic origin. It should be given immediately after or soon after meals.

Cantharides, drop of the tincture every hour, will in many cases relieve vesical catarrh.

For the diarrhea of children, accompanied with slight inflammation, straining, and the passage of jelly-looking matter, but no true dysentery, five drops of castor-oil, given every hour in water with sugar and gum, is an excellent remedy

In orchitis and epididymitis, and dysmenorrhea, not of a membranous, obstructive, or neuralgic character, two minim doses of tincture of *pulsatilla* every hour will afford greater relief than any other mode of treatment. For flatulence, fluttering and palpitation at the menopause, one-fiftieth grain doses of the extract of Calabar bean every half hour for six or eight doses, and similarly repeated after stopping it for three hours, will prove an effectual remedy.

In the headache of migraine, one grain of the citrate of caffeine given every half hour, will often produce most marked relief.

In neuralgias about the face or head, three minim doses of the tincture of *gelseminum* every half hour will often act almost miraculously, and leave no ill-effects.

EAR-ACHE.—According to the *Louisville Medical News*, the best application for ear-ache in children is a few drops of a warm solution of atropia, one to four, allowed to remain ten or fifteen minutes, and then allowed to run out by turning the head over. Usually a few applications will suffice.

OBSTETRICS.

TO FIX THE VESICO-VAGINAL SEPTUM, in operations for fistula, Dr. Rogers, of Memphis, recommends (*Miss. Val. Med. Mo.*) the introduction into the bladder of a rubber bag. This being then distended brings the parts into excellent position for the operation. The bag can be withdrawn, before tightening the stitches, through the vagina, or even through the urethra.

INFANTILE LEUCORRHEA.—The little girl, nine years old, is suffering from a very profuse leucorrhea, which her mother has been unable to cure by any of the remedies which she has employed, and which has now lasted for two months. I, of course, made a vaginal examination, and, on separating the labia, I found that the whole vulva was about the color of red flannel, and bathed with a copious leucorrheal discharge. The meatus urinarius was also seen to be in the same condition, and urethritis has, no doubt, been set up by the spreading of the irritation.

Not infrequently mothers will bring their little girls to you in this condition, and they will sometimes be in a state of great agitation, because they are afraid the trouble has been the result of injury done the children. There is ordinarily no reason whatever to suspect anything of the kind, and you can at once quiet the anxious mother's mind. The affection is a perfectly simple one, and is perfectly curable also. It is generally known as infantile leucorrhea; but infantile vaginitis would be a better term for it.

Now as to its causes. One of the most frequent of these is neglect of hygienic precautions. There is generally no intentional neglect on the part of the mother or nurse; but, on account of the undeveloped condition of the part, an accumulation of hardened secretion sometimes collects in the same way as that which not infrequently gives rise to balanitis in the male child. Another common cause is the depreciated condition of the child's system, such as that due to spanemia, in which all the mucous membranes are apt to become more or less affected. Thus, there is often gastric and intestinal, as well as nasal catarrh. A third cause that may be mentioned is reflex influence from the rectum. The cause of the irritation in the rectum is usually ascarides, and an afflux of blood to the part is caused by the itching and irritation.

In some instances, the ascarides, by getting into the vagina itself, are

the direct cause of the trouble. The prognosis of this affection is, that it can be cured at once if it is properly treated.

In the treatment, the first thing to do is to see if there any worms present, and if so (or there is any reason to suspect that such is the case), use an injection of warm salt water, as this form of ascaris, as well as others, is unfavorably affected by salt. The next thing to do is to get the child's general system in the best condition possible by appropriate food, iron, vegetable tonics, and the hypophosphites. It is better to depend on nourishing diet, however, than on medicinal agents. If after the worms have been gotten rid of the vaginal irritation and discharge should continue, or if no worms should be found to be present, local treatment will be required. The vagina should be thoroughly washed out by means of a syringe provided with a small nozzle, which ought to be well oiled before introduced. In order that the canal may be perfectly cleansed, the child should be placed upon the back. In some cases the mere removal of the accumulated secretion, which is a constant source of irritation, is all that is necessary; but if the trouble has gone on for some time, this may not be sufficient. Something further is then needed, and one of the best applications to use is the old-fashioned black wash (calomel and lime-water) in the strength of one ounce to the pint of water. Before using this (which should be done twice a day), an injection of simple warm water should be made. I have never yet seen a case of infantile leucorrhea that could not be cured by such treatment as this; so that there is no necessity of resorting to astringents and nitrate of silver, which may perhaps do harm. If it is adopted here, I have no doubt that in less than two weeks this child will be entirely well.

But there is one mistake which is apt to be made by the physician in these cases, on account of which a much longer time may be required for a case than is at all necessary, and that is, the failure on his part to show the mother or nurse how to introduce the nozzle of the syringe properly. Mothers, unless they are especially instructed in regard to this point, never carry the nozzle more than an eighth of an inch up into the vagina, and as it is above this that the degenerating pus is found, there will be no improvement, simply because the injections fail to reach the real source of trouble. It is not enough even to show the mother how to use the syringe, but you should also watch her do it, and see that the upper part of the vagina is reached. In a child of this age, the rectal tube of a Davidson syringe should be employed.—From Clinical Lecture by Prof. Thomas, in *Med. and Surg. Reporter*.

SURGERY.

UNION BY FIRST INTENTION IN SCALP WOUNDS.—Dr. Robert T. Morris, of Bellevue Hospital, N. Y., gives the following directions for securing primary union in scalp wounds:

Of course the first thing to be done is to make sufficient pressure to control the hemorrhage, and then the hair is carefully trimmed away from the edges and vicinity of the wound.

After sufficient hair has been removed a thorough syringing of the wound with carbolized water (1-30) should follow, and then a most thorough search must be made for any foreign body, a single hair left in the cut being sufficient to prevent union by first intention in its vicinity.

Twist together two or three horse hairs which have been kept in carbolized oil and lay them in the wound, allowing the ends to project from either extremity, and then, with a medium-sized curved needle, put in enough silk sutures to bring the edges of the skin closely in apposition, taking care that the needle penetrates the entire thickness of the skin each time that it is inserted.

After all of the sutures have been tied, the horse-hairs should be pulled back and forth a little by means of their projecting ends, in order that the canal for deep drainage may be free.

Superficial drainage is next to be looked after, and this end may be gained very nicely by wringing out six or seven thicknesses of cheese cloth in carbolized water (1-30), and applying as a compress on the wound, first rubbing a little iodoform well into the portion which is to come next the skin. Gutta-percha tissue, or any other waterproof material, should then be placed over the cheese cloth, and the edges allowed to project far enough over so that everything beneath will remain moist and warm. A bandage applied not too tightly completes the dressing.

In twenty-four hours the horse hair may be removed, and the dressings replaced. In forty-eight hours or later, the stitches should be removed, and a warm and dry dressing placed over the site of the wound. If the patient is asked to return for examination in a day or two, the wound will almost always be found to have united beautifully by first intention, and a long period of suppuration, with numerous complications, to have been avoided.

When failure occurs in a case like the one described, the causes are usually due to lack of care in the application of the deep or superficial drainage. The sutures may have been tied more tightly than necessary, or some foreign material may have been left in the wound.—*Med. Record.*

THE CLINICAL HISTORY AND LOCALIZATION OF PERINEPHRIC ABSCESSSES.—Dr. John B. Roberts (*American Journal of the Medical Sciences*, April, 1883,) believes that purulent collections in the cellular and adipose tissue surrounding the kidney are very properly termed perinephric, or circumrenal, abscesses. It has recently become somewhat customary to speak of them as perinephritic abscesses, but Dr. Roberts believes that perinephric is etymologically the more correct adjective.

The early recognition of the existence of perinephric abscess, and the determination of its relative position with regard to the kidney is important, as the promptness and efficiency of operative treatment must depend very much upon the early recognition of the exact position of the abscess.

Dr. Roberts arbitrarily divides the perinephric cellulose-fatty tissue into six tracts: the upper, middle, and lower anterior; and the upper, middle, and lower posterior tracts. There is of course no sharp definition between these regions, which are used to conveniently indicate the location of the disease.

It may be premised as an axiomatic truth that, although there may be pains radiating in various directions, anterior inflammation will give rise to pain especially in the front or side of the abdomen, posterior lesions to pain in the loin. Tenderness upon pressure, edema over the abscess and pointing will be similarly exhibited. The swelling, the tumor-like outlines and the feeling of resistance to palpation will naturally be the more evident in anterior lesions because the tissues between the disease and the surface are flaccid. Involvement of the chain of sympathetic ganglia, situated along each side of the spinal column, would occur in posterior lesions only.

The following tabular statement of symptoms is given to assist in the localization of perinephritis and perinephric abscess:—

All anterior regions.—Pain, tenderness, swelling, edema, and pointing in front and side of abdomen.

All posterior regions.—Pain, tenderness, swelling, edema, and pointing in loin.

Upper tracts.—Pleuritic friction, pleural effusion, empyema, expectoration of pus; dyspnea; suprarenal involvement; solar plexus involvement. (On right side.) Bilateral edema of legs; jaundice; fatty stools; persistent vomiting; rapid emaciation; ascites.

Middle tracts.—Albuminuria and casts; suprapubic, scrotal, or vulvar pain or anesthesia; suppression of urine; uremia; pus in the urine; edema of scrotum or varicocele (especially on left side).

Lower tracts.—Flexion of hip; pain or anesthesia of front, inside, or outside of thigh; retraction of testicle; pain at knee; scrotal or vulvar pain or anesthesia, without accompanying albuminuria; unilat-

eral edema of legs; abscess or sinus near Poupart's ligament; constipation (if left side); involvement of chyle receptacle (if right side).

GASTROSTOMY, ESOPHAGOSTOMY, AND INTERNAL ESOPHAGOTOMY IN THE TREATMENT OF STRICTURE OF THE ESOPHAGUS.—Operations on the internal organs of the body have become much more common than they were formerly, and in recent years, the stomach has been very frequently operated on with the view of counteracting the effects of esophageal obstruction.

Dr. Morrell Mackenzie (*American Journal of the Medical Sciences* for April, 1883,) analyzes the cases of this character which have been already published, and gives an account of two new cases.

He finds that gastrostomy has been performed 81 times, and that death occurred from shock in 27 or in 24.6 per cent.

The advantages of gastrostomy are: 1. That it can be carried out with comparative ease; 2. That there is very little risk in the steps of the operation itself, especially if done in two acts separated by a proper interval of time; 3. That there is almost entire certainty of being able to affect the object aimed at, which is the establishment of an alimentary fistula altogether beyond the seat of stricture; and 4th, that the fistula is hidden from sight. The only disadvantage is that gastrostomy still yields a high percentage of deaths.

Twenty-six cases of esophagostomy are analyzed; of these, 16 died within a fortnight, and 7 died from shock.

The advantages claimed for *esophagostomy* are:

1. That it is attended with comparatively little shock.
2. That it facilitates subsequent dilatation of the stricture; while the disadvantages are that the operation is a very difficult one, and attended with considerable danger from its proximity to so many important structures, and there is great uncertainty in any given case whether the opening in the esophagus can be made below the stricture; and finally a discharging fistula in the neck is a conspicuous disfigurement.

Seventeen cases of *internal esophagotomy* are analyzed, and the following advantages claimed for this operation:

- 1st. That it is attended with an inconsiderable amount of shock.
- 2d. That if the stricture can be thoroughly divided, gradual dilatation can be carried out, and a cure thereby effected.
- 3d. That the procedure involves no external wound. The disadvantages of esophagotomy are:
 - 1st. That it can only be safely performed in cases where it is still possible to pass a bougie.
 - 2d. It is often difficult to pass all the strictures.
 - 2d. In many cases, the walls of the esophagus are so thickened that limited longitudinal incision does not relieve the obstruction.
 - 4th. The actual danger in the operation is far from inconsiderable.

NEUROTOMY FOR NEURALGIA DUE TO GANGRENE.—Dr. Morton recently reported to the Philadelphia Academy of Surgery the case of an old lady who suffered intense neuralgia during the course of a senile gangrene of the foot, involving the heel and sole. In her case morphia interfered with digestion, and its benefits were of brief duration. He divided the sciatic nerve near the hip with happy success, being led thereto by previous success with the same measure for elephantiasis arabum, and preferring to make one division of the main trunk rather than several incisions lower down. The course of the gangrene was not injuriously affected. His first experience in case of elephantiasis was generally reported at the time it happened, a few years ago.

FUNNEL-DRAINAGE IN ANASARCA is a method of removing large quantities of fluid devised (*Glasgow Medical Journal*) by Dr. Straub, Tübingen. The apparatus consists of an ordinary glass funnel, of two inches diameter, attached to the end of which is an India-rubber tube one-eighth inch in diameter, and long enough to reach to the floor. The apparatus is filled with water, and the mouth of the funnel firmly applied to the skin of a patient lying in bed, while the end of the tube is immersed in a vessel on the floor containing a little water; it will adhere and act as a sucker; and when the funnel is applied over several small incisions or punctures, in a case of edema, the tube acting as a siphon will keep up a continuous drainage of serum in the vessel. The apparatus, if protected by a small cage or cradle, can be left on for any length of time, and is not displaced by movements of the patient if ordinary care is taken. Enormous quantities of serum have been drained off in this way. In one case of chronic Bright's disease there were drawn off in two and a quarter hours, over seventy-eight ounces; in seven hours, over ninety-six ounces; and in twenty-four hours, two hundred and seventy-eight ounces; and in another case of extreme general dropsy from Bright's disease, nearly forty-three pints were removed in seventy-nine hours.—*Gaillard's Med. Jour.*

CURE OF ABSCESES WITHOUT CICATRICES.—Dr. Quinlan recommends the passage through the abscess of a fine silver wire, which with the ends tied outside will act as a drain. This must be done before the pus reaches the surface, when it is, say, half an inch from the external surface. No poulticing must be used, and when the abscess is evacuated a compress applied. This procedure has never failed in his hands.—*Med. and Surg. Reporter.*

COLUMBUS MEDICAL JOURNAL.

EDITORIAL.

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We have *no authorized Collectors*, except such as carry properly made out bills, *counter signed by the Publishers*.

HANN & ADAIR, Publishers, Columbus.

MEMPHIS SEWERS.—The last number of the *Miss. Valley Med. Mo.*, contains a diagram of the new sewer system of Memphis. The people of that city naturally feel more or less pride in having adopted and perfected so complete a system of sewerage—entirely new and untried upon a scale of any considerable magnitude—with the surroundings and in the brief time in which it has been accomplished. The *general* mortality of the city has not materially diminished since the completion of this work, so we are informed, yet it has not—as has been asserted—increased, while zymotic diseases are much less frequently observed, are more manageable, and the mortality from that source is greatly less.

Memphis has a population of about 45,000, and occupies the summits and slopes on both sides of a valley, which is drained by a stream known as Bayou Gayoso. The main sewers are located on each side of the bayou, and as near it as practicable. There are 38 miles of sewers, of which four miles are mains located along the bayou and discharging into the Mississippi by one outlet; and the remainder are laterals draining into these mains. The mains are ten, twelve, fifteen and twenty inches in diameter. Of the laterals, about 85 per cent. are six inches in diameter, and the remainder eight inches, except a few short lengths, which are ten inches. The mains for the most part are laid with a grade of two inches in one hundred feet, which is the minimum. The minimum grade of six inch laterals is six inches in one hundred feet. At the upper end of each lateral is one of Field's Automatic Flush Tanks, which discharges 112 gallons in about forty seconds, once in twenty-four hours. The system has man-holes distributed on the mains. No surface or roof water is permitted to enter the sewers, the system being designed and proportioned for house sewerage only.

The house drains are all four inches in diameter, and no trap is permitted on the main drain, each fixture being provided with a separate trap. The soil pipes are of cast iron, with lead joints, above the ground, and extend four inches in diameter above the roof. Each house drain is consequently a ventilator for the public sewer. For the purpose of removing the subsoil water, agricultural drain tiles are laid in the trench with each lateral, on the grade of the sewer, or below it, which discharge into the bayou.

A large part of the trenching has been done by contract, but the pipes have been laid with hired labor. The prices last paid for excavating and back filling are as follows: Trenches $6\frac{1}{2}$ feet deep, 25c.; $6\frac{1}{2}$ to 9 feet, 30c.; 9 to 12 feet, 45c.; 12 to 15 feet, 75c., per lineal foot. The pipe laying, including laying drain tile in the same trench, also the cost of the cement, sand, oakum and tile paper, is estimated to cost 7 6-10 cents per foot. The flush tanks cost complete about \$45.00 each, including \$10.00 royalty. The six-inch pipes, although draining houses on both sides, in some cases for a distance of three thousand feet, have never been overcharged, and have seldom been found running half full. No trouble has been caused by sewer gas, and the sewers are believed to be comparatively free from it. Some of the six inch pipes have occasionally been obstructed by sticks, etc., becoming fixed across the diameter of the pipe, all of which have been promptly removed. Twenty-one cases of such obstruction have occurred, which have been removed at the average cost of \$13.50 each.

Some deposits have been found in the mains, which have been rapidly and inexpensively removed by the passage of hollow metal balls through them. These balls are about three inches less in diameter than the sewers, and being lighter than water are pressed against the top of the sewers, and are rolled along by the force of the current. The velocity of the ball is less than that of the water, which in passing it is deflected against the bottom and sides of the sewer so as to thoroughly cleanse it. A portion of the mains have been cleansed four times since their construction; the laterals not at all. Hourly observations in the twenty-inch main, on 30th April last, showed the greatest depth of flow, $12\frac{3}{4}$ inches at 10 a. m.; least depth, 8 inches at 2 a. m. On 13th of June, greatest depth 14 inches at 11 a. m.; least depth, $10\frac{1}{4}$ inches at 4 a. m. Floats in the same sewer gave a surface velocity of 2 6-10 feet per second, the depth being $12\frac{1}{4}$ inches.

4,715 water closets, 3,334 sinks, 179 urinals, 334 bath tubs, 408 wash basins, 34 privy sinks, and 24 cellar drains have been connected with the system, which appears to give entire satisfaction both to the city government and citizens generally.

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.—The report of the Committee of the Association, which has been widely published in advance of the Cleveland meeting, has certainly not been received with any enthusiasm. The medical journals of the country, evidently out of respect to the members of the committee, and especially its venerable chairman, have, with one exception, carefully refrained from any criticism of the report. The exception alluded to is furnished by *Gaillard's Medical Journal*, of New York, which has recently, in an earnest, manly editorial, boldly criticised such features of the report as it regarded as obnoxious. Its strictures, we venture to say, will be pronounced as well taken by a majority of the profession.

In the first place, it is a well known rule of ethics and of parliamentary practice that a nominating committee cannot name one of its own members for any office; if a party is a candidate for any position, his friends must see to it that he is not placed on the nominating committee. Yet this committee of the association nominates its own chairman for the office of editor-in-chief of the new journal—a gross violation of all rule and precedent, which places both the committee and the man it is sought to honor in a most awkward predicament.

Again, the editor of the proposed journal will have an immense amount of personal work to perform, to say nothing of the great responsibility under which he must labor; he must be a man well up in every department of professional knowledge and research, so as to be able to judge of the value of every contribution received for publication; he must have a wide knowledge of the available contributors to the periodical literature of the profession, that he may know where to look for articles; he must be able to secure the services of, direct, and *manage* a large corps of reporters and special correspondents; and he must produce a journal that will compete successfully in all respects with the great weeklies of the eastern cities, and which shall not fall below the standard represented by the *Journal* of the corresponding association of Great Britain. It will not do for him to sit back in his easy chair, and tell the association that the journal is theirs and will be what they make it: he must make it himself: he must be to the journal and to the association, what Ernest Hart is to those of Great Britain.

Having thus shown what the editor must be and assume, it would seem to be self-evident that a man seventy years old cannot physically meet the requirements of the position. A quarter of a century ago, N. S. Davis, of Chicago, would have been the spontaneous nominee, for the position, of nearly every member of the association; but, while regarding him with reverence as a father in medicine, and with deference as an advisor, there

are few who will not say that his age is too great, and his ideas and prejudices too much of the past, to warrant the association in jeopardizing the interests of the journal by selecting him as its chief editor.

The position taken by Dr Gaillard, whose points we have summarized above, cannot fail to be regarded as a strong one.

Of those at present engaged in editorial work in this country, we know of none who are seeking the position, nor, indeed, who would likely accept it. I. Minis Hays, whom we named months ago, would seem to be, perhaps, the most available man, but it is not certain that he would accept.

THE STATE SOCIETY.—The Committee of Arrangements of the Society reports to the effect that the Society will hold one session, to listen to the President's address and reports of committees, and to transact routine official business; that it will then adjourn for one year, as usual, and that the members, on payment of \$5 each, will be entitled to all the privileges of members of the American Medical Association, except voting, into the meeting of which the meeting of the Society will be merged.

Quite a number of the members, however, object to this summary disposition of the State organization, claiming that such a course would be apt to result disastrously to the best interests of the Society. It is very likely, therefore, that a compromise will be effected, by which the Society will merely meet and adjourn until, perhaps, some time in December or January. This latter course would seem, on many accounts, to be preferable, as the organization of the Society would be more systematically maintained, and its volume of *Transactions* appear as usual.

AMERICAN MEDICAL ASSOCIATION.—The next annual meeting of the American Medical Association will be held in Cleveland, June 5th to 8th inclusive. All railroads west of Pittsburg, Salamanca and Buffalo, east of Chicago and south of Cleveland, will carry delegates and members of their families, to Cleveland at one full-fare, and return them on a certificate signed by me as Chairman of the Committee of Arrangements (certifying that they have been in attendance at the meeting of the Association), at one cent per mile.

The Trunk Lines east of Buffalo, Salamanca and Pittsburg, and lines west of Chicago, have refused to make any reduction. The rates *per diem* at the hotels will be: Kennard House, \$3; Weddell House, \$3; Forest City House, \$2.50 to \$3; American House, \$2.50; Hawley House, \$2; Striebinger House, \$2; Clarendon House, \$2; Prospect House, \$2.

X. C. SCOTT, M. D.

Chairman of Committee of Arrangements.

JEFFERSON MEDICAL COLLEGE.—Dr. Roberts Bartholow, Professor of Therapeutics and Materia Medica, has been elected Dean of the Faculty, in the place of Dr. Eilerslie Wallace, who has resigned on account of ill health.

SOCIETY PROCEEDINGS.

CUYAHOGA COUNTY MEDICAL SOCIETY, REGULAR MONTHLY MEETING, MAY 1, 1883.

Restriction of Medical Colleges—Amer. Med. Association—Change of Meetings—To Increase the Influence of the Society—Inguinal Hernia—Pancreatic Juice.

DR. E. D. BURTON, President, in the chair. The first business in order, after hearing the minutes of the previous meeting, was the report of committees. Dr. SIHLER, chairman of the committee appointed to investigate the practicability of a resolution passed by the Society: "To use its influence to prevent any more Medical Schools being chartered in the State of Ohio, without consent of the profession, inasmuch as though said schools admission into the profession is gained," reported as follows: The committee finds that in the State of Ohio no charter is required to start a medical school, and, therefore, nothing can be done by the means pointed out in the resolution. The committee, thinking the aim of the resolution a timely one, recommend—

First, That this Society in the near future discuss the questions that follow: *A.* Is it not the duty, as well as to the interest, of the profession, that the power of admitting candidates into its ranks be taken from the medical schools and given to the profession, where it properly belongs? *B.* Can this object be best attained by a State Board of Health taking the matter in hand, or is the State Society a body which can execute this trust?

Second, That the Corresponding Secretary be instructed to advise all the Societies in the State, of the subject-matter of this report, invite them to advance the subject, and to communicate their resolutions to this Society, or to the COLUMBUS MEDICAL JOURNAL. The Society resolved to discuss these suggestions at its next regular meeting.

Miscellaneous Business.—Dr. THAYER moved the Secretary appoint delegates to the American Medical Association from those (not members of the association,) desirous of attending. *Carried.* Dr. Thayer's motion to have delegates to the State Medical Society appointed by the Secretary, was also carried.

Dr. BENNITT submitted the following: Resolved that this Society, through its President, welcome the American Medical Association to this city, and that the Committee of Arrangements be requested to arrange for such remarks of welcome in the opening exercises. *Carried.*

Dr. TUCKERMAN's motion to change the day of meeting from Tuesday to Thursday, thereby accommodating members also of the Northeastern and Northwestern Societies, was carried.

The Essayist, Dr. Carpenter, not being prepared, the discussion: "How can we best improve the usefulness of this Society?"—was opened by Dr. TUCKERMAN, who remarked on the small average attendance and the notable absence of many of the representative men of the profession here, giving as reasons for such absence, and consequent lack of interest in original work: 1st, The time of meeting, which conflicted with the office hours of many, and the engagements of lecturers in the medical colleges. 2d. The lack of any collection in this city of the leading scientific journals from the principal medical centres of the world, so that no question could be thoroughly worked up. 3d. Discourteous language used in discussion, unrebuked by either Chair or Society, deterred many from membership.

Dr. JONES followed. He said the retiring President's address, which led to this discussion, did not imply the Society was not already in a prosperous condition, but he thought a permanent place of meeting would still increase its usefulness. He thought the Public Library, if requested by the Society, would get all periodicals required. He said, further, if the minutes were printed it would stimulate to greater exertion in preparing papers, etc. He also spoke of having eminent men deliver lectures before the Society, and of having a collector appointed. He did not favor an evening meeting.

Dr. HUMISTON compared the working of the New York Societies, and favored evening meetings and the procurement of journals.

Dr. SIHLER thought lectures were impracticable, but that a permanent plan of meeting was, and he suggested a committee on the same. He had heard expressions in debate that if used to himself

would have hurt him very much, and he thought the chair should rigidly enforce parliamentary language.

Dr. PRESTON thought it would be difficult to raise money for the proposed improvements.

Dr. TUCKERMAN favored the idea of the Secretary making an abstract of the proceedings, and sending them to the COLUMBUS MEDICAL JOURNAL.

This discussion led to the appointment of a committee to confer with the Board of the Public Library with regard to procuring medical and scientific periodicals, and to the Secretary being authorized to try to secure the publication of an abstract of the proceedings in the journal named.

Reports of Cases.—Dr. W. H. HUMISTON reported cases of concealed strangulated herniæ, as follows:

“J. H., aged 67, male, general health good, bowels inactive; has had a reducible left inguinal hernia 15 years, and has worn a truss constantly. April 17th, he fell fourteen feet, striking upon his back, was unable to rise; after being assisted to bed, where he remained two hours, he felt better and was able to walk; bowels did not move. April 21st, took aloes, after which bowels moved twice; an hour later his hernia came down, but he replaced it without difficulty, as had been his wont, but he continued to feel generally indisposed with an uneasy feeling in abdomen, with complete anorexia. April 22d, he took to his bed, and the day following I first saw him. He had been vomiting and complained of much distress in bowels, and intense thirst; temperature normal; pulse 80. A thorough physical examination revealed absolutely nothing abnormal, save a slight tenderness upon deep pressure at a point, midway, on a line from the umbilicus to the centre of inguinal canal on the *right side*. He plead for something to move his bowels. I gave him an enema of warm soap water, which was soon returned without fecal matter. Ordered ice to suck, and Liq. Opii camph. to be taken when restless. Little change took place, until the 26th, when he had stercoraceous vomiting, followed by marked collapse. Up to this time my diagnosis had been a partial paralysis of the bowels, from shock caused by the fall. It now became evident an obstruction existed, but at what point it was impossible to say. Consultation was called, and I suggested an explorative incision; but as no point of obstruction could be settled upon, and on account of the collapse, it was not entertained by the Consulting Surgeons. He died April 28th, 24 hours after

the last consultation. Autopsy showed no abdominal distension; adipose tissue deposited in abdominal walls to the extent of two inches. Upon exploring the intestines, a knuckle of the ileum was found passing through the internal inguinal ring and firmly grasped, with slight evidence of inflammatory action; the gut was intact, as you see in the specimen before you.

"The case is important on account of the few important or distressing symptoms up to the time of fecal vomiting; the sudden onset of collapse, and its persistency to death; and especially important inasmuch as it gives rise to the question, Was not an explorative incision the proper procedure, notwithstanding the collapse?

"A few days later, I was called in counsel to see a patient with symptoms of obstruction of the bowels; age 40, male, had complete inguinal hernia eight years; easily reducible; never worn a truss. Eight days previous to my visit he was attacked while at work with a sharp pain in the lower part of abdomen; was compelled to lie down; became worse; vomiting began, followed by thirst; constipation complete; a physician was called, who replaced the hernia easily and without pain; vomiting continued; the doctor distended the colon by injecting three quarts of warm water, which caused severe pain, and was rejected immediately without fecal matter; symptoms of collapse ensued, and I was called. Reaction was finally established, and the patient expressed a desire for food; vomiting ceased, but no passage from bowels had taken place. We thought advisable to again distend the colon, and a quart of water was injected. It was retained fifteen minutes, but no fecal matter appeared. Symptoms of collapse again took place, and we were compelled to resort to free stimulation. Upon examination, the hernia was found to be out; it was replaced, and a graduated compress and bandage applied. After this the patient began to improve; had free evacuations, and the vomiting ceased.

"Was not this hernia completely reduced and retained by the compress? and were not the two cases identical, save in degree? the first being a *concealed incomplete irreducible hernia*; the second, a complete and and seemingly reducible hernia, although not completely reduced until a compress was applied."

Dr. TUCKERMAN showed a specimen of pancreatic juice, obtained by direct catheterization of the pancreatic duct through a permanent fistula in the duodenum. The animal used was a large dog.

WILLIAM T. CORLETT, M. D., Sec'y.

FEE BILL

Adopted by the Central Ohio Medical Association,

APRIL 8, 1888.

This Fee Bill is designed to indicate merely the charges for ordinary services in families in comfortable circumstances. In cases which require extraordinary attention, or involve unusual responsibility, the charges will be increased accordingly.

Mileage is to be added in all cases, at the rate of 50 cents per mile, or \$1 when roads are bad. In all surgical cases, subsequent visits and dressings are to be charged at usual rates. Where medicine is furnished it is to be charged for at reasonable prices.

Office Business.

	COUNTRY.	TOWN.
Ordinary prescription, or advice by telephone..	\$.50	\$ 1.00
Physical examination.....	1-3	2-5
" " very minute.....	3-10	5-25
Vaccination.....	.50	1.00
Teeth, extraction of.....	.50	1.00
Electricity, dressing of injuries.....	1-3	2-5

Practice.

Visits, (Night visits double. Small pox and to strangers, \$5.).....	\$ 2	\$ 2
Consultation.....	5	10
Written opinion.....	2-5	3-10
Opinion involving legal issue.....	25	25
Insurance certificate as family physician.....	2	2

(To be paid by the Company.)

Obstetrics and Gynecology.

Natural Delivery (including two visits, except mileage).....	\$ 10	\$ 15
Detention over six hours, per hour.....	1	2
Delivery of placenta alone.....	5	5-10
Forceps, or turning.....	15	25
Craniotomy, or evisceration.....	25	50
Vaginal examination.....	5	5-10
Uterine applications.....	1-3	3-5
Introduction of pessary.....	2-5	5-10
Lacerated cervix or perineum.....	25-100	25-100
Vesico-vaginal fistula.....	100-500	100-500
Cesarean Section, Porro's operation, or Gastro-Elytrotomy.....	200-500	200-500
Uterine tampon.....	10-20	10-20
Removal of ovarian tumors.....	100-300	100-300
" " uterine polyps or fibroids.....	50-300	50-300

Surgery.

Administration of Anesthetic.....	\$ 3
Amputation of finger or toe.....	5
" " through meta-carpus, or -tarsus.....	10
" " forearm or leg.....	25

Amputation at shoulder, or through arm or thigh, (Heys', Chopart's, Pirogoff's, or Syme's operation).....	\$ 50- 100
" at hip-joint.....	100- 200
" of breast.....	50- 100
Reducing dislocation of finger or toe.....	5
" " at knee, elbow or shoulder.....	25
" " at hip.....	50- 100
" " of jaw.....	15
Setting Fracture of finger or toe.....	5
" " of radius (Colles').....	15
" " of " and ulna.....	20
" " of arm.....	20
" " of clavicle.....	15
" " of ankle or leg.....	35
" " of femur.....	50
" " of jaw.....	25
" " of rib.....	10
" " of patella.....	50
Sewing up Wound.....	5- 20
Opening Abscess.....	2- 5
Introduction of sound or catheter.....	3- 10
Rectal examination.....	5- 10
Excision of tonsils.....	10- 15
Removal of nasal polyps.....	5- 10
" hardened cerumen.....	5- 10
Fistula in ano, or fissure.....	25- 100
Hemorrhoids, external.....	10- 25
" internal.....	25- 100
Paracentesis.....	20- 50
Injecting hydrocele.....	20- 50
Removal of small tumor.....	5- 10
" large ".....	25- 100
" jaw.....	100- 250
Circumcision.....	25- 50
Hare-lip.....	25- 50
Tenotomy.....	10- 50
Plastic operations.....	25- 250
Excision of joints or bones.....	25- 100
Ligation of small arteries.....	10- 50
" large ".....	50- 250
Introduction of stomach tube.....	10- 25
Plugging nares.....	10- 25
Plaster-jacket.....	25- 50
" of Paris dressing.....	5- 10
Trephining.....	25- 100
Laryngotomy or tracheotomy.....	25- 100
Lithotomy or lithotripsy.....	100- 500
Hernia, reduced by taxis.....	25- 100
" " operation.....	50- 200
Adjusting truss.....	5- 10
Gonorrhea, in advance.....	10- 25
Gleet, or syphilis, in advance.....	25- 100
Urethrotomy.....	50- 100
Cataract.....	50- 150
Iridectomy, or enucleation of eye.....	50- 100
Strabismus.....	25- 100
Ectropion.....	25- 50
Entropion.....	25- 50
Opening nasal duct.....	10- 25

The above Fee Bill is the standard of the ASSOCIATION, and its members have pledged themselves, as physicians and gentlemen, to its maintenance.

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No. 12.

COMMUNICATIONS.

THE MICROSCOPE IN THE DIAGNOSIS OF DISEASES OF THE KIDNEYS.

BY I. F. MARKEL, M. D., MIFFLIN, O.

Read before the North Central Ohio Medical Society, at Mansfield, March 28, 1883.

The difficulty of making a diagnosis of some of the diseases implicating the kidney, is apparent when we consider how little is said of the details for the investigation of such diseases in the many text-books on general practice. Had the general practitioner the leisure, the proper means at his disposal, and, from previous training, a fitness for exact observation, we should find in a general practice one of the most valuable fields for renal pathology ; as here, and here only, we have before us the earliest signs of departure from health, the various changes, the insidious or violent attack, and the only opportunity for tracing Bright's Disease from its beginning to its end. Nothing is said in those same text-books in regard to the preparation *necessary* for a microscopical examination of the secretions from the kidneys, although some are illustrated by drawings of the microscopical appearance of the sediment.

A cursory examination of our medical journals reveals the sad fact that very little space is ever devoted to the microscope and its value in medical research, and the occasional brief article that is found on this branch of medical science can seldom be credited to our home physicians. It is also to be deplored that our medical schools, or, at least, a vast majority of them, make no attempt to teach any method for investigation in microscopical technology.

Many young men are each year sent from our colleges as "practitioners of medicine" with no knowledge whatever of histology, pathology, and the normal and abnormal secretions of the human body, as revealed by the microscope. One should think that a great number of medical men would possess and be able to manipulate this wonderful instrument. But the revelations of it, and the progress in medical science credited to it, have failed to enthuse the busy practitioner who graduated from a school where the microscope was not one of the methods of teaching, or a means for investigation; and now few find time for learning and taking up this new occupation and method of advanced investigation.

The value of the microscope in the differential diagnosis of certain diseases is such that in some of those of the kidney it is impossible to make a positive diagnosis without its aid, and in all it will diffuse some light on their nature by a careful examination of the urine under a one-fourth inch objective. However, to obtain reliable data in diagnosis, no hasty or occasional examination is of much value, but only repeated, careful, and continued observation will reveal the disease and indicate its course.

The general practitioner must have a definite knowledge of the histological structure and of the pathology of the kidney, in order that the instrument may be of any aid to his diagnosis.

Physiology teaches that the function of the kidneys is to take from the system nitrogen and water, and at the same time from the blood many of its salts. Hence, the excretion is the most accurate index of the condition of the organs. Here, then, we have ground for the maxim, "whenever in doubt of a positive diagnosis, examine the urine carefully and thoroughly." Da Costa says: "But to glean the full benefit from an analysis of the urine, we must be acquainted with its complex composition, and be able to explore it qualitatively and quantitatively, and be accustomed to examine its deposits with the microscope."

The normal salts of the urine, the urates, uric acid, the phosphates, creatine and creatinine, are all most readily distinguished by the microscope, but the chlorides and sulphates are more easily found by chemical tests. The significance of these normal salts, when present in excess, cannot be spoken of in this paper.

Of the abnormal substances found occasionally in the urine, we find sugar, bile and leucine better detected by chemical means until microscopy is more advanced; but these substances, when found, do not indicate disease of the kidney, nor does tyrosine, which is readily detected by its long, shining, crystal needles, under a moderately high power.

The oxalates are most readily detected with the microscope, but their significance does not pertain to our topic, though their presence denotes some nervous or gastric derangement.

In considering blood as a foreign element found in the urine, a careful study is necessary to localize the origin of the hemorrhage, and this can only be accomplished with the microscope. When the hemorrhage denotes a lesion of the kidney, the instrument shows the renal epithelium, which is characterized by being globular, and frequently accompanied by and entangled with the small casts of the uriniferous tubes, while the blood particles which come from the bladder are mixed with more or less vesical epithelium, which is flat and scaly, and readily distinguished from that of the kidneys. But this, to be of any value in differential diagnosis, must be supplemented by a careful observation of all the symptoms, local and constitutional, connected with the urinary derangement, as well as a careful examination of all other foreign matter found with the blood and all its characteristics. The blood corpuscles which we detect with the microscope are not always of uniform appearance, and are never seen to collect in rouleaux.

Another substance most readily discovered by the aid of the microscope is fat, but in this it is well to confirm our discovery by the means which chemistry so readily affords. Here we must guard very carefully against errors, whether the fat denotes such a degeneration, or is chylous, or in free globules, or associated with albuminuria and tube casts, and attended by dropsy, or whether it comes from the ingestion of such articles as contain fat in large quantities. Fat may continue in the urine in free cells without albumin for years, and not denote disease of the kidney.

Another substance of much interest to the microscopist and diagnostician, is pus as found in the sediment of the urine. Dr. Fell, in a paper read before the Medical and Surgical Society of Buffalo, last September, said: "With the microscope the pus corpuscle is readily recognized, and this use of the instrument is alone so far-reaching in its value as to warrant the statement that it alone furnishes sufficient reason for the teaching of microscopical technology in every medical college throughout the land." Though the pus corpuscle may sometimes be indistinct, and become a source of error when the urine, on being voided, is strongly ammoniacal, by being confounded with that of the mucus corpuscle, heat and nitric acid make a ready test; for where pus is found albumin is also present, but with the mucus corpuscle albumin is never associated, although entangling quantities of epithelium cells, thus adding microscopical evidence. The localization of the source of the pus is, by close study, much enlight-

ened, for the corpuscles from the kidney are irregular in contour and nuclei, and with partially destroyed cells. The corpuscles of the bladder are regular.

"The presence of albumin in the urine is considered by the majority of physicians as the index of a pathological condition, although Bernard, Hoffman and others have pointed out that albuminuria may be met with in persons whose health is perfect, and under certain conditions of alimentation." M. Marcacci has proved that albumin may be found in a physiological urine, by a series of observations on himself. Albumin, therefore, denotes nothing except when found in connection with the different tube casts. But albumin means casts in the vast majority of cases. It is the small quantities of albumin that may lead to an error, which may not only confuse the physician but complicate the patient's chances for recovery. The small quantities of albumin may come from the blood or pus, or possibly from the prostate or urethra. Albumin is also found in the urine where lithic acid is eliminated.

Now, noting some of the diseases of the kidneys wherein the microscope reveals the signs whereon a diagnosis is based, we shall begin with those in which tube casts are found in the sediment. The urine should be fresh for a microscopical examination, and from the nature and the character of the casts the differential diagnosis is made. In an article in the *London Lancet* we find this proposition: "Neither dropsy nor albumin is usually present in chronic Bright's Disease, and when present they denote acute or epithelial change." The most generally accepted account of the disease and its symptoms fails to recognize it in by far the larger number of cases in which it already exists. One of the most fatal forms of Bright's disease is where there is interstitial inflammatory destruction, with little or no albumin, but with tube casts, which are hyaline and pale granular, and which tell to the physician of an ending which, if the patient but knew it, would make his heart sink within him.

In the acute form of the disease, or acute nephritis; we have narrow hyaline casts, epithelial casts and cells, and blood casts, which all signify the acute catarrhal stage of nephritis, such as follows scarlet fever or exposure to cold and wet. These are accompanied by much albumin, the urates and uric acid, and sometimes even oxalates. Fatty and waxy casts belong to the chronically enlarged kidney, and a preponderance of any kind affords an indication of the exact state of the kidneys. Broad hyaline casts, and dark, granular, epithelial casts—the urine first highly albuminous, but further along in the disease slightly so—are usually found in

that form of renal chronic disease which ultimately results in the wasting and shrinkage of the kidney.

In renal hematuria much can be done, and readily, by investigating the sediment, thus learning whether it is due to cystic degeneration, cancer ulceration, tuberculosis, or irritation from a calculus, and each must be studied with the symptoms and physical signs, but each has in the field of the microscope its peculiar characteristics. In intermittent hematuria we find crystals of the oxalate of lime. In cysts, if containing a parasite, the vesicles will show its characteristic structures, but in ordinary cysts the microscope is of no value as yet. In nephralgia, in its various conditions, the microscope is of value in diagnosis, but here we may find the feature which is the index to be wanting at times. In suppurative nephritis there is blood and pus, and all the casts found are seen to be covered with pus corpuscles. In pyelitis we may have the crystalization of the nitrate of urea into irregular blades set at angles, and some feather-like crystals. In abcess of the kidney, and in perinephritis, the microscope is yet of doubtful value in making a positive diagnosis, and will be until the science has made more progress. In simple albuminuria there is no exudation, hence no tube casts can be detected in the urine, except occasionally after a long search.

In conclusion we would only say that in so wide a field much is yet to be added, by diligent investigation, to what is already known; and in the near future, much that is now speculation in renal diagnosis and pathology will be clear and definite, and he who will make a diagnosis will apply his eye to the microscope.

HISTORY OF A CASE OF DYSTOCIA, CAUSED BY INTRA-UTERINE HYDROCEPHALUS.

BY C. H. HUMPHREYS, M. D., OF DAYTON, O.

Mrs. G——; aged 19; primip., eight months pregnant; was taken in labor about 10 A. M.—I was called about two hours afterwards. The cervix was flaccid and dilatable, but nearly closed; the pains were irregular and not of much force. Her general health during gestation had been excellent. Hoping to quiet the pains and carry her to term, gave a full hypodermic dose of morphia, which, assisted by twenty grains of chloral one half hour later, had a temporary effect only. Being summoned again at three o'clock the next morning, found the patient in the second stage, the breech presenting. The pains were moderately strong and regular,

and soon the breech and shoulders were born. The head remained completely arrested at the brim, nor could I determine why it should. The pelvis appeared, as well as I could make out, sufficiently roomy; the child was small and had been dead several days. In abdominal palpation the uterus was but little diminished in size apparently. Twin pregnancy was suspected, though the abdominal walls were too thick to determine satisfactorily. I made careful examination of the pelvic cavity, and found the head partially engaged at the superior strait; no obstruction or deformity could be found. The pains continued and the patient was encouraged to assist them. Pressure from above could not be made to much advantage, owing to the large size of the abdomen, and was soon abandoned. The various methods of effecting delivery in head last cases were used but proved ineffectual. When traction was made with the finger in the mouth, the jaw gave way.

The patient was then placed in the obstetric position for the application of the forceps. After introduction the instrument could not be made to lock, the handles failed to adjust; they were reapplied and considerable force used to bring the handles together. The effort burst the head. A large quantity of water poured from the vagina, and the collapsed head was easily withdrawn. The head had been an enormous sac, and the rupture occurred over the vertex. Patient's recovery was protracted. Involution of the uterus became arrested. Metrorrhagia existed for weeks, with consequent anemia, complicated with pronounced melancholia. Eventually she recovered perfectly.

DEATH FROM CHLOROFORM.

BY M. J. JENKINS, M. D., OF PLAIN CITY, O.

Reported to the Central Ohio Medical Society.

H. C. W——; aged 30; consulted me about February 1st, 1883, concerning a very painful affection of his finger. He stated that while playing the violin the evening previous, he became suddenly conscious of a stinging sensation at the inner aspect and extremity of this finger, which grew rapidly worse, assuming pain of a very severe and lancinating character, and compelling him to desist further playing and go home. He spent a sleepless night, and when he came to my house presented a very dilapidated aspect. Upon examination, I found a deep-seated inflammation of the ring finger of the

right hand, which I regarded as a *Felon*. The pain at this time was of a throbbing character, and there was present marked constitutional disturbance. In searching for a cause, I could only find that it must have been produced by the friction of the bow.

The patient was a man of exceedingly dissolute and irregular habits, and at this time was indulging himself in one of his frequent and protracted sprees. I advised him to keep the wounded member saturated with alcohol for twelve hours, hoping thereby to cut the inflammatory process short, as I had done in such cases before. At the end of twelve hours I was sent for, and found an aggravated condition of the disease, with an extension of the inflammation toward the hand and forearm. I immediately made two deep and free incisions, one on each side of the affected phalanx, not with a view to give exit to pus, notwithstanding suppuration frequently occurs early, but to relieve the tension and mitigate the inflammation by a plentiful escape of blood, which, however, did not escape, but instead, a small quantity of a sanious discharge. I then ordered warm poultices to the hand and finger, with laxatives and anodynes internally, and a positive interdiction of stimulants. In the succeeding few days the disease developed all the characters of a diffuse cellular inflammation, involving the contiguous fingers and the outer half of the palmar surface of the hand; in other words a positive phlegmonous erysipelas. The treatment applicable to that condition was then instituted, viz.: quinine and iron, and the constitutional condition of the patient was so much improved that serious apprehension concerning the local manifestation of the disease was allayed. At the end of two weeks, the affected finger, beginning at the extremity, became sphacelous, and the phalanx was exsected before any distinct demarcation became visible. My patient was now in a better condition physically than he had been for a long time previous, plainly showing in his countenance the effects of the tonic, together with the reform in his habits. He was now eating and sleeping well, suffering but little pain, and walking out and about town every day. But at this stage he returned to his old habits of drink, and a continued debauch was not long in producing its effects. The disease returned in all its malignancy, and not only in the affected part, but also in others. The granulations in the finger broke down and became unhealthy; gangrene developed, and a further operation became imperative. The patient was put off from time to time, in the hope that he would reform, at least long enough to be prepared for the operation, for he was determined to have an anesthetic; but no reform being probable, and he becoming very impatient, I determined to do it at once.

On the 2d of April, I called to my assistance Dr. J. E. McCune, a skillful and experienced physician of many years' practice. I had concluded to excise at the metacarpo-phalangeal articulation, but upon a joint examination we decided that to enucleate at the middle phalangeal joint would serve to arrest the disease and possibly preserve the patient a portion, at least, of his finger. He was again cautioned regarding the dangers of chloroform, but insisted upon its administration. He was placed upon a lounge, in the recumbent position, in a large, well ventilated room, with his mother and an older brother present. The anesthetic (Squibb's purified chloroform) was administered by Dr. McCune, from a folded handkerchief held at a distance of five or six inches from the nose and gradually brought closer, but at no time allowed to touch, so that during the whole time there was a plentiful admixture of air. The patient was somewhat slow in being brought under its influence, and twice when experiencing its excitation, raised up and was exceedingly obstreperous. However, when consciousness fully returned, he was anxious to have it administered, so laid down and inhaled it quietly. When unconsciousness supervened the operation was begun (palmar flap method) and the administration of the anesthetic stopped. In this connection I wish to state that at no time during the operation was reflex motion totally abolished, as evidenced by the patient's efforts to withdraw his hand from mine while operating. When the operation was completed there was nothing about the condition of the patient to give rise to any alarm, but while we were examining the bone higher up, which was found to be in a state of necrosis, he began to vomit. His brother, standing near his head, instead of turning him on his side raised him up, when the vomiting was so excessive that he could not be laid back immediately. However, as soon as practicable he was replaced in the recumbent posture, but the extreme pallor of the countenance foreboded death, though it was unaccompanied with the usual symptoms of stertorous breathing. The doors were immediately thrown open, the heart sounds listened for, but in vain. The tongue was drawn out to facilitate the opening of the larynx, the patient inverted to favor a flow of blood to the brain, artificial respiration resorted to and persevered in for an hour, and stimulants and friction applied to the skin; but all to no purpose—our patient was *dead*, and had been from the time he was laid back on the lounge.

Respiration continued apparently for a few moments after the heart ceased, but was undoubtedly only a delusion produced by the mechanical means used in the effort at resuscitation.

The query with us is, how was death produced? Was it by apnea, or was there paralysis of the heart. I am of opinion it was the latter, and think I am sustained in this opinion by the almost instantaneous development of the fatal symptoms, viz.: want of perceptible heart sounds, absence of stertorous breathing, and want of that peculiar cyanotic hue due to imperfect oxygenation of blood.

I have thus hastily and briefly given a history of the case, in order that you might be acquainted with the condition of the patient at the time of operation, and not with a view to shirk any blame that might reasonably attach to me. The contraindications to the use of an anesthetic in this instance existed chiefly in the poisoned condition of the blood. That he had partaken of a hearty breakfast on the fatal morning, and subsequently of four ounces of whiskey, was not known to us until he was seized with vomiting, the vomit consisting of large quantities of food, plentifully flavored with the odor of bad whisky. His being raised into a sitting position while vomiting, militated against him, and a neglect to supply ourselves with the means for the application of electricity in case of accident, was a careless act, deserving of its just censure. That such precautions against accident were neglected has produced its full measure of self-reproach, and the probability that the patient would have died in any event is but feeble consolation for our carelessness. The quantity administered was less than an ounce.

[As the report of this case gave rise to considerable discussion among the members of the Society, as to the manner of death, and even as to whether the chloroform was the real agent, we have submitted the report in full to Dr. J. C. Reeve, of Dayton, whose opinion in a matter of this kind can be accepted as final. He has kindly responded as follows:

"1. The man died from chloroform; I cannot see any ground for the slightest doubt.

"2. He was a bad subject; hard drinkers have furnished a large contingent of fatal cases from chloroform.

"3. He was in a bad condition at the time of inhalation—he had a full stomach.

"4. The immediate, exciting cause of death was the inadvertance of raising him upright. Any sudden change of position of the body when under an anesthetic is dangerous, especially change from the horizontal to the upright.

"5. Death was by paralysis of the heart, and there need be no regrets that a battery was not at hand. The ultimate pathology, in all probability, was either sudden and profound anemia or change in cell action, of the circulatory nervous center in the medulla. The only rational modes of rescue were by lowering the head and the administration of nitrite of amyl; the latter, presuming that respiration did continue for a brief period after the heart's action ceased.

"6. The case is a striking example of the delusion of the doctrine that an alcoholic stimulant before the inhalation of chloroform secures immunity from accident. In this respect it does not stand alone. The preliminary dose of whisky has a wonderful effect in sustaining the heart of the administrator! That is, if he fully believes in it."—EDS. JOURNAL.]

CLINICAL LECTURE.

CIRRHOSIS OF THE LIVER.

BY STARLING LOVING, M. D.

Delivered in Starling Medical College, Nov. 1, 1882.

GENTLEMEN: This patient's name is C. G. His age is 44 years. He is a native of Bavaria, but has been long a resident of the United States; he is married. He is a baker, and has followed his trade with unremitting industry from youth up to the present moment. Though suffering from illness for several months past, he has continued his work as usual.

He is of medium height and well developed, but presents the appearance of illness and suffering. His hair is dark, eyes gray and features regular. His features are somewhat pinched in appearance and sharper than is natural. I presume he had originally a fair skin, but it is now discolored and dark from jaundice. The skin is moist, and apparently of normal temperature. The pulse is 88, moderately full, soft and compressible. The patient has been walking rather rapidly and may be somewhat excited because of his unusual surroundings, facts which may account for the unusual frequency of the pulse. You observe on the cheeks several irregular spots of a dusky red. The lips are bright red, and there are some slight abrasions about the nostrils. The tongue is red at the tip, but furred in the centre and toward the base. The breathing is somewhat hurried, and the respiratory movements impeded and shallower than normal. The abdomen is disproportionately prominent, and has a broad groove or indentation from side to side, across its middle, which apparently has been caused by the compression of the clothing. The umbilicus is somewhat more prominent than usual. The body and superior extremities are evidently somewhat emaciated, while the legs are swollen from edema. On the right leg there is a large patch of sub-acute eczema. The skin is discolored throughout by jaundice, but is smooth and shiny. Although the breathing is impeded, there is no pain in the chest nor cough. Inspec-

tion shows no disproportion between the two sides. The vocal fremitus is normal. The percussion notes are normal. Auscultation is negative. The impulse of the heart is normal, except that it is perhaps more widely diffused than we should expect were the patient in health. The sounds of the heart are normal. The patient's appetite is good, but he is, and for many months has been, distressed by what he calls dyspepsia—uneasiness after eating, with gaseous, acid, or bitter eructations. The bowels are habitually constipated, but are now somewhat loose from the effects of some crab orchard salts which I prescribed for him day before yesterday.

The urine is ordinarily scanty, dark and turbid; but at times is abundant and pale. One day last week he was unusually constipated, and the secretion of urine was very scanty—he thought from slight fever, the result of a fatiguing journey to a neighboring county. He took a dose of oil, which purged him freely and seemed to excite at the same time a free flow of pale, watery urine. The ordinary tests give negative results. There is dullness on percussion over the lower regions of the abdomen, with pretty distinct fluctuation. There is tympanitic resonance over the course of the transverse colon, and in the inferior epigastric and superior umbilical regions. The area of the liver dullness is less than normal, the diminution being most distinct on the left. The lower border of the liver is quite distinct, but is not much below the ribs. The organ is firmer than in health, and its surface is uneven, studded with small nodules, which are easily distinguishable. Pressure over the liver causes no pain, but there is a degree of tenderness over the region of the stomach, extending to the umbilical region. On the right side of the abdomen you observe that the subcutaneous veins are more tortuous than natural and somewhat enlarged, forming a very distinct Medusa's head. The spleen is enlarged and somewhat tender. The patient's family history is good. His parents lived to a good old age, and his brothers and sisters, of whom there are several, are in good health; to use his own expression, "as hearty as bucks." His own history is good. Until the beginning of his present illness, he never suffered from any serious attack, constitutional or acute, nor has he ever had severe injury. His habits have been good, except for many years he has been what is called, giving the expression a liberal construction, "a moderate drinker." Like all his countrymen, he is fond of beer, and he takes kindly to spirits when in the society of good fellows. As I remarked a little while ago, his appetite is good, even now, and he has always indulged freely at the table without, until lately, any unpleasant results. His avocation is a laborious one, and necessarily exposes him to sudden and very great alterations of temperature, and consequently to disturbance of the functions of the skin.

His health continued good until some time about the middle of the year 1881, when he began to suffer from disorder of the stomach. He had uneasiness after eating, distention of gas in the stomach, with unpleasant eructations. Many articles of food which he had before enjoyed distressed him. The functions of his bowels also became deranged; long periods of constipation would be succeeded by a day or two in which there was diarrhea. The urine became scanty and turbid. There was, and continues to be, a sense of fullness in the abdomen, which is always increased by exertion and fatigue. About this time a year ago he began to suffer from hemorrhoids and had a slight bleeding from the bowels, which he attributed solely to the piles. Not long afterwards he had epistaxis, which was more profuse than the melena, but not enough blood was lost to occasion alarm, or considerable prostration of strength. There has been bleeding from first one and then the other of these surfaces repeatedly since, most frequently from the nose. The last attack, one of epistaxis, occurred within a week and was quite severe.

The patient consulted me first on the 19th of March last, complaining of dyspepsia, fullness and weight, with a degree of distension and tenderness of the abdomen, which had so increased as to occasion some alarm, particularly as he had taken some medicine without decided relief from any of the symptoms. His general condition was then somewhat the same as now. There was jaundice; the stigmata were upon the face, the lips were red, the tongue was coated, the speech was abrupt, the voice resonant and harsh, the gait, as now, was that of one who carries a burthen in front, and the respiration was embarrassed, but not so much as at the present. There was, in less degree, the same disorder of the functions as now. The abdomen was tumid, but there was not so much dropsy as now, nor was there dropsy in any other part of the body. The area of liver-dullness was then diminished, especially on the left, while that of splenic dullness was increased almost to the same extent as now. The lower border of the liver could be felt much more distinctly than now, was higher in the hypochondrium than natural, and, as at present, was pushed outwards. The inequalities, or nodosities on the surface of the organ, to which I called your attention a few moments since, were more definable because there was less dropsy. They were most distinct in the left lobe of the liver.

The patient has mentioned to-day one symptom which I do not remember to have heard him refer to before. He complains now of pain under the right shoulder blade. This is not uncommon in diseases of the liver; in fact, it is so frequently present as to be regarded in a measure diagnostic, particularly in the more acute diseases of the organ.

I prescribed abstinence from alcohol, an occasional warm bath, laxatives (the sulphate of magnesia, and afterwards the phosphate of soda), some quinine, and afterwards small doses of corrosive sublimate, with decidedly good effect. That is, there was improvement in the general health, a change toward the normal in the secretions, less tumidity of the abdomen, but there was no appreciable alteration in the condition of the liver. The treatment was changed from time to time. The mercury was suspended, and the bicarbonate of potassa, with compound infusion of gentian, was given for a while instead. At one time during the summer there were symptoms of intermittent fever, and quinine was again prescribed, and afterwards the liquor arsenitis potassæ. The condition of the portal circulation and of the secretions was kept constantly in view, and the patient did well until in September, when he yielded to his appetite for drink and soon grew worse, and, in addition to his former symptoms, had edema of the legs, which has continued until now.

What is the disease? My diagnosis is cirrhosis; chronic atrophy of the liver, chronic interstitial hepatitis, or chronic sclerosis of the liver, as it is variously called by different writers. It is also called, in common language, rum liver; hob-nail liver, from the nodules on the surface; and gin drinkers' liver. Cirrhosis is the name under which it is usually described. This term, which signifies yellow, or orange yellow, was applied first by Lænnec, who either did not understand the pathological anatomy of the disease or chose to distinguish it by the color of the organ principally affected, rather than by something more significant of its nature. Chronic atrophy, or chronic interstitial hepatitis, are better names because they refer more directly to the changes which take place in the liver, and the nature of the disease; but I presume it will always be called cirrhosis or hob nail liver.

This malady is of sufficiently frequent occurrence, but it is not so common in this country as ordinary diffuse hepatitis. It appears to be more prevalent in Great Britain than in the United States. Its subjects are much more frequently the inhabitants of cities than of "rural districts." It is stated that it sometimes attacks children, but its victims are almost always adults between the ages of 35 and 60 years. The larger proportion are males, but females are not exempt. It is not confined to any class. It is frequently observed here among politicians.

Etiology.—It is possible that, in occasional cases, this malady may arise from constitutional syphilis and other causes, but in the great majority, nay, I may say almost all, the cause is alcohol, "spirit tippling," the habitual intemperate use of distilled liquors, such as whisky, gin and

brandy, taken in the undiluted form. Strong wines and malt liquors will cause it, but their use is not so dangerous in this direction as spirits. It is not necessary that enough be taken to cause habitual or even frequent intoxication, but only a quantity adequate to maintain a state of excitement and irritation in the stomach and liver. Hence cirrhosis is as often found among so-called "moderate drinkers," as among those known as "drunkards." Many of the latter class, after "sprees," while suffering from pain and disordered functions, from remorse and degradation, make good resolutions and abstain a sufficient length of time to allow their organs to return to something like the state of health before yielding again to their habit. In consequence some of these people live to a good old age, and finally die in the contemplation of a thorough reform.

The etiology of cirrhosis is then sufficiently simple. The undiluted or but little diluted spirit is swallowed, most frequently when the stomach is empty—a short time before meals, or midway between meals—is immediately absorbed and passes within a few minutes almost unchanged from the stomach (where it produces first effect) into the portal circulation and into the liver, to stimulate that organ in turn. It must pass through the smaller veins embedded in the connective tissue, before it reaches its ultimate destination—is detained briefly, and it is fair to presume that the strongest influence is exerted there. Whether this be true or not, the connective tissue of the liver is the part in which the morbid change begins and continues, and the change partakes of the nature of inflammation. There is hypertrophy from proliferation of that tissue, which so increases as to press upon and displace the proper gland structure. the smaller blood vessels, hepatic and portal, and finally to destroy the gland structure in large part and occlude the lesser vessels; the terminal branches of the portal vein, it would seem, to the greatest extent, at least the effects of the occlusion of these veins are most striking and important. The destruction, however, does not proceed equally in all the parts affected, hence here and there are found spots or islets of structure in which there is incomplete or no change, and these form the nodules or hob nails which characterize the disease. By the diminution and occlusion of its branches, continued congestion of the portal vein, and its dependencies, results, and presently the hemorrhages mentioned and ascites and the symptoms arising therefrom. Continued obstruction to the portal circulation is the cause also of the hemorrhoids, and of the dilatation of the sub-cutaneous veins of the abdomen and the formation of the "Medusa's head." There is an anastomosis between the interior mesenteric and hypogastric veins through the inferior hemorrhoidal, which makes the connection tolerably direct,

and through which nature attempts to establish collateral and compensatory circulation. In the main, the symptoms, except the jaundice, are such as arise from obstruction to the portal circulation.

The liver, during the first stage, while there is hyperemia of all its tissues from the continued irritation, and previous to the characteristic structural change, is enlarged instead of diminished in bulk, and may continue so for a length of time. In some cases the increase is so considerable as to be easily detected, but in many it is not so great and is never detected. Even when discovered it cannot be distinguished from enlargement due to ordinary congestion. Sooner or later, generally before there are symptoms which lead to a suspicion of serious lesion, inflammation of the connective tissue (the cirrhotic change) is established, and through the occlusion of blood vessels and the destruction of the gland structure, atrophy begins. The morbid process with the consequent atrophy is in some cases partial and remains so, leaving the remainder of the organ in the normal state; but generally it is continuous, although it does not proceed with equal rapidity in all parts. In other cases the disease may be general, and advance sufficiently to cause serious symptoms, and yet, through the removal of the cause and treatment, be arrested, it may be finally; but usually after a few weeks or months, it becomes again active and is not checked until life is destroyed. Hence there are recoveries in some cases, and some have remissions or apparent recoveries and relapses. Although the disease may be arrested and the subject regain good general health, no part of the liver which has been changed by its progress is ever restored to the normal state. In a few cases the malady runs an acute course, passing through the different steps and reaching its termination in death within a few weeks, but usually it is essentially chronic, its course running through many months.

It is impossible to explain the remarkable difference in susceptibility to the attack of this disease. Many notorious debauchees pass long lives and die with sound livers; while other persons who drink comparatively little, and who would be horrified at the thought of being considered intemperate, suffer early in their career. The drunkard is in greatest danger, but a man who drinks habitually is not safe.

The course of the malady is divided into two stages. The first embraces all that occurs from the beginning to the period when the morbid change in the connective tissues is fully established, and atrophy of the gland begins; and the second, all that occurs afterwards, including the further change in the liver and the symptoms which result from obstruction to the portal circulation, hemorrhages, diarrhea,

hemorrhoids, dropsy, &c. In the main the symptoms of the first stage consist in indications of impairment and derangement of the functions of the stomach and liver ; such as discomfort and fullness after ingestion, acidity of the stomach occurring after meals and arising from fermentation of the food, gaseous eructations, nausea, and sometimes vomiting, especially in the morning, a furred tongue and an unpleasant and sometimes bitter taste. The appetite is capricious, and there is a craving for highly seasoned articles of food, and acidulated condiments. The desire for strong drink increases; the bowels are generally constipated, but at intervals constipation is alternated with diarrhea, after which the patient experiences temporary relief. The urine becomes scanty and dark colored from bile pigment. There is a sense of weight and fullness in the region of the liver and stomach, with not unfrequently a degree of tenderness and dull pain in the liver, extending to the right shoulder. The skin is dry and harsh, and early tinged with jaundice; the breathing is somewhat hurried, and there is, toward the beginning of the second stage, a change in the voice, which acquires a higher pitch than in health. If examination be made, the liver may be found to be enlarged so as to extend the area of hepatic dullness considerably beyond its normal limits, but perhaps as often no enlargement can be detected; on the contrary, the first investigation sometimes reveals diminution instead of enlargement. All the symptoms which have been mentioned belong as frequently to disordered digestion, as observed in the intemperate, as to cirrhosis; nay, all save the jaundice and the changes in the liver, are observed in varying degree from time to time in most persons who drink to excess, so that they cannot be considered highly diagnostic, yet when they are persistent, especially if associated with appreciable changes in the size of the liver and jaundice, they should excite close attention.

There is not, as before said, any accurate division between the first and second stages. When the liver is shrunken in size ever so little, the second stage has begun, but it is not possible to discover the atrophy in its incipency; we can only detect the change when it has so far advanced as sensibly to diminish the volume of the organ.

In the case before us, now well advanced in the second stage, the disease has followed what may be called the typical course. For many months prior to seeking medical advice, our patient had suffered from the symptoms just described as belonging to the first stage, including, during the latter part of the time, jaundice and pigmentation of the urine. Although uncomfortable and sensible of increasing debility, he would not acknowledge himself ill until he found his abdomen becoming swollen

and his breathing obstructed. When I saw him first, early last spring, there was marked diminution in the size of the liver; the nodulations were very distinct, the organ was high in the hypochondrium, and its lower border tilted forward and outward, so that it was more prominent than natural, and more easily distinguished by palpation. There had been several attacks of epistaxis, several of diarrhea, and the patient complained of hemorrhoids fully as much as now. His voice had acquired the peculiar qualities to which your attention has been called. He had the same discoloration of the skin, there were the same eructations, and many other symptoms of dyspepsia, which are present to-day. The features had already assumed the sharp and wasted look which they now present, and as I have said, there was a slight accumulation of fluid in the peritoneum. All these are symptoms of the second stage. As the disease advances, as it will surely do, those we have observed may increase, and others may appear. The obstruction to the portal circulation will become more complete, and there will be an increase in the dropsy, not only in the abdomen, but in the extremities, and possibly in other parts. The functions of the liver will be more nearly suspended, and there may be an increase of jaundice, but this is not so certain as the increase of the other symptoms, and if it should happen, the case will most likely terminate shortly in coma and death. As the diaphragm is pushed upward by the accumulation of fluid in the abdomen, the dyspnea will grow more distressing, and sub-acute bronchitis may supervene. If there is no bronchitis, the sympathetic cough which you have heard will continue. Other attacks of diarrhea, and possibly melena, may occur. The hemorrhoids may become more and more annoying; the urine may remain as at present or become more dense, more deeply tinged with bile pigment and more scanty, or finally it may become nearly or quite suppressed. If the quantity is much diminished below the present, the patient will become stupid or comatose from the retention in the blood of urea, and bile elements, and die. The emaciation will progress, and the size of the trunk will become still more disproportioned to that of the head and extremities than now. The legs may become more dropsical, and finally enormously large, while the arms will show the extent of the emaciation. The medulla's head will become more distinct, and veins in other parts of the body will give evidence of the obstruction to the return of blood. The ascites frequently becomes so great as to occasion, through pressure upon the abdominal organs and the lungs and heart, not only discomfort but even danger to life. With such great derangement to function and nutrition as

necessarily happens, even without dropsy, the patient is prone to complications, as pneumonia, carbuncle, erysipelas, &c.; such are likely to prove severe and intractable, and more dangerous than under ordinary circumstances. Finally the nutrition fails altogether, and the patient dies from asthenia, combined with the influence of the various disturbances which have been mentioned.

From what has been said, you will infer that the diagnosis of cirrhosis in the early part of its course is difficult, if not impossible. Knowing the patient's habits, we may suspect the probability of its existence when the evidences of disordered and impeded digestion persist and continue to increase in gravity. If, at the same time, the nose becomes more deeply tinged with the lurid hue common to tipplers, and stigmata make their appearance upon the face, along with a tinge of jaundice, there is stronger suspicion, which will have confirmation if the liver be found enlarged and tender, and there is pain on motion in the right hypochondrium and in the right shoulder. These symptoms collectively, or several together, with the exception of the venous discoloration of the nose and face, arise from diffuse hepatitis, and even from congestion of the liver, but in either case they are usually accompanied by febrile disturbance, their appearance is abrupt, and they do not continue through weeks and months, as in cirrhosis. Because of this similarity between symptoms, the existence of the disease is in many cases not suspected until the second stage is fully established—the patient becomes dropsical, and examination reveals atrophy and nodulation of the liver. There is no great difficulty in the diagnosis of the second stage. If the patient's habits are intemperate, if there is protracted dyspepsia with gaseous eructations, slight but persistent jaundice, progressive emaciation, noticeable first in the face, stigmata on the face, a change in the voice, repeated attacks of epistaxis, or hematemesis, or both, hemorrhoids, occasional attacks of diarrhea alternating with long periods of constipation, a change in the gait, a degree of tenderness and pain in the right hypochondriac and epigastric regions, the pain extending to the right shoulder, ascites, and atrophy with roughening of the surface of the liver, there is little danger of error.

We derive assistance from remembrance of the fact that cirrhosis is one of several diseases which cause atrophy of the liver. Acute yellow atrophy can scarcely be taken into account, as its course is so rapid and its symptoms so different from those of the disease under consideration. Besides, it is uncommon, and its subjects most frequently are women not intemperate. The liver becomes atrophied from the effect of the long continued congestion incident to tricuspid and mitral insufficiency. This

form of atrophy is easily recognized from its connection with the antecedent disease of the heart, and from the fact that while the liver is reduced in size, the diminution is symmetrical, and the surface of that organ is smooth. Syphilitic disease may be known by the history of the case—the eruption and other symptoms, and from the fact that although the liver is lessened in bulk, and its surface nodulated, the nodules are larger than in cirrhosis, and separated from each other by broad furrows, or depressed bands, extending across its surface. It must, however, be remembered that syphilis and tippling are not incompatible, and that it is possible for syphilis and cirrhosis to exist simultaneously. In the examination of such cases, the practitioner will find it necessary to draw upon his reserve store of sagacity and knowledge. In peri-hepatitis, the peritoneal covering is sometimes thickened and condensed so as to cause a degree of lessening in the bulk of the viscus, but this form of disease is of comparatively rare occurrence, and there is usually something in the history of the case which points to its true character.

Except during the first stage, there is not much probability that you will mistake chronic atrophy for any of the diseases which cause enlargement of the liver. It is most likely to be confounded with *passive congestion with enlargement*, sometimes passing into sub-acute diffuse inflammation, of which cases are now and then seen among persons of intemperate habits, and, as frequently, among those whose lives are regular, especially in malarious districts. This condition is consequent on the influences of malaria, conjoined with the effects of dissipation, or upon the influences of malaria and heat. It subsides when the fever is cured, or with cold weather and the disappearance of the cause; or when it follows a debauch, relief comes with repentance and the purgative action of blue mass and senna. *Cancer* of the liver is most commonly secondary; that is, it occurs chiefly in connection with and after the development of cancer in some other organ, usually the stomach, and may attack by contiguity of structure, or through embolism, the cancerous virus being conveyed through the circulation, and lodged in the hepatic tissues to find a suitable soil for propagation. It is usually medullary, and found in one or two large masses near the central portion of the organ which it has invaded, or is distributed in lesser masses at various points nearer the surface. In the first case there is general enlargement, with a central prominence or bulging; in the second, there are several protuberances of considerable size, always larger than the hob-nails of cirrhosis, separated by considerable intervals, circular in shape, more or less flattened, and frequently umbilicated, or cupped in the centre. There is more pain in cancer than in cir-

rhosis, and its progress is more rapid, death occurring within a year, or, at most, within eighteen months from the beginning. Jaundice is not a uniform symptom in cancer, in fact it is frequently entirely absent, but it is sometimes present in an intense degree, especially when the disease extends by contiguity from the lesser end of the stomach. The constitutional symptoms are, from the first, more decided and of graver character; emaciation and loss of muscular strength are rapid and extreme. Early in the course of the disease, the surface becomes extremely pallid from anemia, which, as you know, is always a prominent and progressive symptom of cancer wherever located. Toward the close, when the strength is nearly expended, the feet and legs become edematous, and sometimes there is ascites, but dropsy is not so constant a result of cancer as of chronic atrophy of the liver. *Hydatiform disease* of the liver is almost unknown in our region of country, and can scarcely be counted among the diseases to be differentiated in any case, but it may be recognized without difficulty by its peculiar symptoms, of which the most striking is the appearance of one or more large, painless, fluctuating tumors, generally near the central portion of the liver. *Fatty degeneration* is not uncommon in persons of intemperate habits. This form of disease causes enlargement equally distributed, while the surface of the organ remains smooth and soft. Fatty degeneration occasions considerable obstruction to the portal circulation, sometimes so much as to cause dropsy, but the accumulation is never so great as when the result of cirrhosis. In none of the diseases of the liver, in which there is atrophy, save acute yellow atrophy and cirrhosis, nor in any of those characterized by hypertrophy of the organ, is hemorrhage from any part of frequent occurrence.

The patient's habits and the history of the case will usually enable us to distinguish cirrhosis from disease affecting the kidneys and other abdominal viscera; but it is well to remember accurately the location of each organ, and the changes in size and position which are apt to occur through disease. I once saw a case of what was supposed to be malignant disease of the pancreas mistaken for chronic atrophy of the liver, nor was the error discovered until the *post mortem* examination revealed the true nature of the case.

Prognosis.—The termination of the disease is generally disastrous. If it be detected in the first stage, and the patient has sufficient firmness to forego his habit, it may be cured, but usually self-control is lost, and the readiness and earnestness with which promises of reformation are made is only evidence of the degradation which the sufferer has reached. In some cases, even when the second stage is well established, the further progress of the malady is arrested without treatment, provided the cause be with-

drawn, but in the majority, the progress of the inflammation is steadily onward; the functions of the liver become more disturbed, the portal circulation is more completely arrested, there is catarrh of the intestinal mucous membrane, dropsy appears, is relieved and re-appears, there are repeated hemorrhages or attacks of diarrhea, the nutrition fails, and the strength is exhausted; or waste is retained and the patient becomes comatose, or has convulsions and sinks.

Treatment.—This is not satisfactory; on the contrary, in most instances it is of little avail, mainly because we are not consulted until the liver has been injured beyond repair. With the proper course, if correct diagnosis be made, during the incipency of the disease, there is room for reasonable hope of success; but after the second stage has become fixed, we can do little more than palliate symptoms as they arise; unfortunately, we cannot always succeed in this as we desire. The first step is, to interdict absolutely the use of alcohol in any shape, and regulate the diet. The second is to regulate the functions as best we may, so as to relieve the portal circulation and the liver. The diet should be nutritious and easy of digestion, but should not contain starchy or saccharine elements in large proportion. *Exercise* in the open air, with light work should be enjoined. Purgative doses of Epsom or Rochelle salts, or, better, the old-fashioned compound infusion of senna should be ordered and repeated until the portal circulation is relieved as far as possible. The *kidneys* may be stimulated to increased action by the use of acetate of potassa, dissolved in infusion of Juniper berries; or squills may be administered in connection with cremor tartar, or in the form of diuretic wine, as recommended by Stille. White Sulphur and Blue Lick waters, or some of the imported mineral waters, such as the Seltzer, Pullna, Friedericshall, or Hunyadi, will serve afterwards, to keep the bowels and kidneys in action—and they may be assisted, when necessary, by an occasional dose of calomel or blue pill, with or without colocynth, aloes or podophyllin. The secretion from the *skin* may be increased by the internal use of diaphoretics, but this end, when circumstances permit, is better attained by warm vapor baths, proper clothing, and exercise. The simultaneous use of sulphur water as a beverage, and heated, as a bath, has a powerful influence on the kidneys and skin, and is not without effect on the functions of the liver. Simultaneously, or after the effect of these remedies, we may administer *mercury* in the shape of corrosive sublimate, for its so-called alterative effect. Dr. Murchison lays stress on the effects of the green iodide of mercury, and Dr. Bartholow recommends the chloride of gold; I prefer the corrosive chloride to the iodide of mercury, and I must say that I have never seen any good in any disease from the chloride of gold. We should be careful of the influence of mercury when there is an excessive anemia. Iodine internally and externally is an excellent alterative, and good may be accomplished from the external application of mercurial ointment. Bitter

and chalybeate tonics may be used simultaneously or alternately with the alteratives. *Hemorrhages* are to be checked by astringents, such as the persulphate of iron, ergot and ice. *Diarrhea*, when excessive, may be controlled by ordinary measures, but a degree of caution should be observed in the application of means for this purpose, as the discharge from the bowels is an effort on the part of nature to relieve the portal circulation, and should not be checked too quickly. When, as often happens, there is *gastric* and enteric *catarrh*, with profuse secretion of mucus, balsamic medicines, especially copaiba, are useful. Should the patient become stupid or *comatose*, the blood and brain should be relieved through the influence of purgatives, diuretics and diaphoretics, as already mentioned. Of diaphoretics, jaborandi is the best. *Carbuncles*, boils and other complications are to be treated on general principles, modified as nearly as possible to suit the existing circumstances. *Dropsy* may be relieved by the use of purges and diuretics—by the remedies already mentioned, especially the acetate of potassa and squills, or more powerful means required. Elaterium and podophyllin, or elaterium with cremor tartar, may be used when milder purgatives fail, but such cannot be often repeated, as they are sure to cause irritation of the stomach and bowels, and rapidly exhaust the strength.

The propriety of tapping generally comes to be considered, and we have usually to decide in the affirmative. The operation should not be deferred too long, but it is best not to undertake it until after the failure of other reasonable means, and until the abdomen has become so much distended as to occasion inconvenience and a degree of peril from the obstruction to the respiration, the action of the heart, the functions of the stomach, and of the kidneys. It may be performed with the ordinary trocar, or better with the aspirator, and to lessen the danger of inflammation, it is best not to empty the peritoneum completely of fluid. Tapping, unless delayed too long, is always followed by great relief. Sometimes, owing to the removal of pressure, the functions of the kidneys and of the bowels are resumed almost with normal vigor, and the patient may recover some lost ground. After the peritoneum is evacuated, medicines now and then operate in a more satisfactory manner, and we obtain results which before seemed improbable. The relief is, however, usually temporary only, the fluid soon gathers again, and a repetition of the operation will become necessary, and after a time, either from the pressure used to assist in the discharge of the fluid, or from the morbid state of the membrane, peritonitis ensues and the patient will die. Now and then it happens that the inflammation proves adhesive in character, the surfaces of the membrane are glued together, preventing the re-accumulation of fluid, or the adhesion is partial, and the cavity is diminished in capacity, so that the further collection is small. This happened under my own observation a few years since, and I hoped the patient might recover, but he died eventually of enteritis, induced, apparently, by additional work thrown upon the mucous membrane.

NOTE.—This patient died a few weeks after his appearance at the clinic, and the autopsy confirmed the diagnosis in every particular.

SYPHILIS AND ITS TREATMENT.—There are, at Vienna, three professors in connection with this subject; two ordinary, Zeissel and Neumann, and one extraordinary, Auspitz. Neumann is the successor of the late Prof. Sigmund.

In the general hospital, the treatment of syphilis in its various stages is essentially the same as that pursued by the late Prof. Sigmund. It differs in many points from that followed in England and America, which is that of the French school.

1st. *The Treatment of the Local Sore.*—The term *hard chancre* is now never applied to the local sore, for the simple reason that an infecting sore may be either hard or soft. These qualities do not depend on the nature of the poison, but on the anatomical structures of its seat. Where there is much connective tissue, as in the prepuce, the sore will be hard; but where there is little of this tissue, as in the glans, the sore is soft. The mineral acids, or the thermo-cautery, are never used for the destruction of the local sore. The conclusion has been arrived at that, after forty-eight hours from the time of infection, treatment of the local sore by escharotics is useless in preventing general infection. It can extremely seldom happen that an infecting sore will be seen by a physician as early as forty-eight hours. The treatment by removing, with the knife or scissors, infecting sores, has been given up here, for it was never found to be of any benefit in preventing the general infection.

The treatment of the chancre is always of the mildest kind. If it is an ulcerating surface, iodoform is invariably used, and generally in the form of spray. One part of iodoform dissolved in six parts sulphuric ether, sprayed on the surface of the ulcer, leaves a fine coating of the former intimately adherent to all parts of the surface. This method of applying iodoform is much better than simply dusting it on, on account of its adhering to the ulcerated surface better. After a few days use of iodoform, the sore takes on "healthy action," and when the granulations are healthy it is no longer advisable to use iodoform, but to employ in its place a 2 per cent, carbolic acid solution. When the chancre has healed, and there is left simply a nodule, the best application is one part of corrosive sublimate to fifty parts of water.

2d. *The Treatment of the Second Stage of the Disease.*—Is it possible to prevent the secondary symptoms of syphilis? This question is answered distinctly in the negative here. It is considered certain that there are no known means that can prevent the infection of the system once the local sore has become fairly seated. Sigmund has found, from the observation

of many thousand cases left untreated, that in forty per cent. the secondary symptoms are very slight, so slight that in quite a number of the cases they escape the patient's observation. The treatment of the secondary stage of the disease is not commenced until the particular form that it assumes is evident. If the patient has an excellent constitution and a good appetite, it is not considered necessary to give him either iodine or mercury, for it is claimed that robust health, with a good appetite, and strict attention to personal cleanliness, stand next to mercury and iodine as antidotes to the poison of syphilis. During the two or three years that the secondary stage is supposed to last, the patient has two or more relapses, and as a relapse is always more difficult to get rid of, it is recommended when the first secondary symptoms are slight not to give either iodine or mercury, but to reserve these agents for a later period. If iodine is used for the first crop of secondaries, it will be found to have much less effect on the second or third crops than if it had not been used in the first. This statement applies also to mercury. It is further maintained that this is true not only of the different crops of the second stage, but also of those of the third stage of the disease. If iodine is used for the treatment of the second stage of syphilis, it will be found to have much less effect over the tertiary symptoms than mercury, and if mercury is used for the secondary stage, it will be found to have a less influence over the third stage than iodine.

As a rule the practice here is to give iodine during the secondary stage, when the symptoms are of a pronounced character. If they do not readily yield, or if the iodine is ill borne, then mercury is given. Mercury is also given if the case is a particularly severe one. Iodine is considered to be as useful during the secondary as it is during the tertiary stage of the disease.

In either stage it is not like mercury, a direct antidote of the poison, but acts indirectly by its favoring tissue changes, and increasing the resisting powers of the patient. Whatever preparation of iodine or mercury is used in the treatment of syphilis, only harm results if digestion is materially interfered with. This is a point of great practical importance, and one too often neglected. For the severer and most rebellious forms of the secondary stage mercury must be used.

In scrofulous and tuberculous subjects it is very often found that neither mercury nor iodine has the wished-for effect, until the patient has taken for some time iron or cod liver oil.

The rule that is generally followed here as to the choice between the iodides and mercury is to give the former in the moist and the latter in-

the dry secondaries. The division of the secondaries into dry and moist is considered to be one of great practical importance. It will always be found that the dry eruptions occur in the weak and badly nourished, while the moist occur in the strong and well nourished.

There are three methods in use in the administration of mercury: 1. Inunction. 2. Internal. 3. Hypodermically. The method by fumigation has been discarded. *Inunction* is the method most commonly employed. It is certainly for the great majority of cases the most trustworthy. By no other method can we get the system so quickly under the influence of this drug. In gummata of the nasal septum, roof of the mouth, etc., where hours are precious in order to save the tissues from destruction, it should always be used. In syphilitic lesions of the nervous system (be the change from a circumscribed gumma, or from the blocking of an artery by cellular infiltration), where irretrievable damage will happen in a very short time, the introduction of mercury into the system by inunction should always be a part of the treatment. Whatever else is given, mercury should never be neglected in these cases. To treat these cases with iodide of potassium alone is considered by Neumann to be only half treatment. After the third inunction mercury can generally be found in the urine, and after the fifth, there are distinct signs of stomatitis. The following is the process followed in the inunction cure, the preparation generally used being a finely divided ointment, made up of one part of mercury and two of lard. After a warm bath, the patient commences the first day of treatment by rubbing the ointment into the external and internal surfaces of the legs. The surface over the tibia is avoided on account of the ease with which eczema is produced. On the second day, the inner surfaces of the thighs; on the third, the sides of the trunk; on the fourth, the inner sides of the arms and forearms; and, finally, on the fifth day, by an attendant, over the back, on each side of the spine and about a hand's breadth from it. Only a small portion of ointment is taken at a time—a piece not larger than a pea—and this rubbed slowly until the parts are dry, the process being continued until the desired quantity has been used. It always requires half an hour, and often an hour, before one drachm can be rubbed in. On the sixth day, the patient gets a warm bath, and on the seventh day he commences the rubbing again, and follows the same order as before. This process is continued until the symptoms disappear. In the secondary stage it requires from thirty to fifty rubbings for this end to be obtained. It is extremely rare to find a case in the second stage that resists sixty rubbings. A very important point in carrying out this form of treatment is to insist upon the patient keeping

his mouth and gums clean. Unless this is done a severe stomatitis is apt to set in, which necessitates the discontinuance of the treatment. The remedy above all others that is best for the prevention of a too severe, or a too early stomatitis is tar—the ordinary *pix liquida*. When stomatitis has set in, it is best treated by tar also. It is surprising how soon it effects a cure in even very severe cases of mercurial sore mouth. If a patient after ten or twelve rubbings has not a slight salivation, with swelling of his gums and a coppery taste in his mouth, it is a certain proof that he has rubbed badly. The rubbing of mercurial ointment into the skin is apt to induce eczema in some people; this, and the fact that it takes up some time, are the only objections to this method. The latter objection, however, can be got rid of by using a preparation made by mixing one part of mercury with two of green soap. The addition of a very small quantity of glycerine helps to divide the mercury. From one to one and a half drachms of this preparation can be rubbed into the skin in ten minutes. It is as liable to cause eczema as the ordinary ointment.

The internal administration of mercury, no matter what preparation is used, is apt to give rise to catarrh of the stomach. It is also a very exact method, for we can never be sure what amount of the drug is absorbed. Calomel is used for children and weak persons. It is especially good in hereditary syphilis. It is usually given in the form of powders with sugar, and in doses for adults of from one-fourth to three-fourths of a grain three times daily. Corrosive sublimate is only used for adults. It is given either in pill form or solution in the usual doses.

The subcutaneous injection of mercury is also extensively used in Neumann's wards. It is only used, however, in the treatment of the secondary stage and the slight forms of the tertiary stage. For the severer forms of the latter stage its action is too slow.

In using mercury in any form it should be remembered that it is very slowly excreted. Considerable quantities can be found in the urine three weeks after any has been used. After a month's inunction treatment, it can still be detected eight months afterwards in the urine. Prof. Ludwig has several times found mercury in the urine of some of Sigmund's cases three, four and five years after they had stopped using it.

There are three different preparations of iodine used here in the treatment of syphilis. They are the iodide of sodium, which contains sixty per cent., the iodide of potassium which contains eighty per cent., and iodoform which contains ninety-three or ninety-four per cent. of iodine. The iodide of sodium is better for children and weak persons. Iodoform is only used hypodermically, one part of iodoform dissolved in six parts of

ether being the formula used. It does not give rise to any local reaction, and its injection is not painful. For mild cases twenty injections will be sufficient, but for the severer forms fifty are often required. Iodoform is considered to be as useful as the iodide of potassium in either the secondary or tertiary stages of the disease.—*Canada Med. and Surg. Journal.*

APOMORPHIA, A SAFE, CERTAIN, AND QUICK EMETIC.—Mr. Brown, L. R. C. P., of Bacup, writes :

It has occurred to me, in several cases, to have patients who have been obnoxious to ordinary emetics. The emetic has caused nausea and depression but no emesis. A few weeks ago, two cases of this kind occurred in my practice. One was a man who had been drinking and eating indigestible food. Domestic emetics had been given, which had produced nausea and ineffectual attempts at vomiting. It occurred to me that apomorphia, used hypodermically, might succeed. I prepared a solution containing a grain of chloride of apomorphia, twenty minims of rectified spirit, and water to two drachms, of which I administered ten minims hypodermically, which equals one-twelfth of a grain. In seven minutes, it produced free and copious vomiting. There was no nausea, no depression, nor intolerance of food. The other case was a man who was a total abstainer. Patient had loaded his stomach with a mass of indigestible food, which had caused him acute pain in his stomach. He had tried domestic remedies without success. Pain was so severe that I was called up at night. The other case having been so successful, I at once administered ten minims of the solution. In two minutes, without any previous nausea or warning, the contents of the stomach were violently ejected on the floor, the patient not having time to get a vessel to vomit into. This was repeated two or three times at short intervals, and the patient had speedy relief. In this case, there was no nausea or bad after-effect.

From inquiries which I have made, I am convinced that the value of apomorphia as a safe, certain, and quick emetic, is not appreciated, because not known. In cases of alcoholic and narcotic poisoning, it is a most valuable remedy, and judging from my experience in one case, the emesis is delayed a few minutes. In cases of acute gastralgia, and convulsions in children, due to overloaded stomach, apomorphia will prove a speedy cure. I have given one-sixth of a grain of the drug to children by the mouth, without producing any effect whatever.—*British Medical Journal.*

HEREDITY IN CRIME AND INEBRIETY.—The following instance has just come to light at Taunton, Mass., in a trial for burglary, where one of the criminals turned State's evidence, whose ancestral history runs as follows : Two hundred years ago or more, a noted pirate abandoned the sea, and settled in the neighborhood of Boston. A numerous progeny came after him, all more or less criminal and drunken. In the third generation from the pirate, there were sixteen inebriates, in the fourth generation in the direct line, twenty-six members were punished for various offenses against law and order, mostly for theft and forgery. In the fifth generation came the notorious Malbourne Briggs, who, at one time, was in State Prison, with seven of his sons, for various offenses. The sixth and seventh generations furnished a scattering crowd of criminals and inebriates, whose records are found in every penal institution in the State. The last representative, who turned State's evidence, seemed to have no consciousness of right or wrong, or moral responsibility, although possessed of considerable genius.

This remarkable lineage is a striking illustration of the laws of heredity, which have yet to be studied before we can understand them thoroughly. —*Journal of Inebriety, April, 1883.*

CASCARA SAGRADA.—The cascara sagrada, or sacred bark—the *Rhamnus purshiana* of the botanists—has of late found favor as a remedy for chronic constipation. As is well known, other members of the same genus possess purgative properties, notably *Rhamnus catharticus*, or buckthorn. The fluid extract of cascara, introduced by Messrs. Parke, Davis & Co., is a reliable preparation, and, in doses from half a drachm to a drachm, proves efficacious. The cascara cordial made by this firm is an extract of the same species of rhamnus, combined with aromatics. It is by no means unpalatable, and is usually taken without difficulty.—*British Medical Jour.*

LACTOPEPTINE.—It has been our custom to call the attention of the profession to this invaluable agent—regularly at this period of the year, on account of its special adaption, among many other indications, in the treatment of cholera infantum and other infantile disorders, prevalent during the spring and summer months. We would be at a loss to get along without *Lactopeptine* in many affections, such as dyspepsia, vomiting in pregnancy, bowel indigestion, and the various troubles of children from non-assimilation and poor digestion.—*Editor of Southern Clinic.*

SURGERY.

PARACENTESIS FOR EMPYEMA.—The real dangers directly attendant upon the operation may be briefly enumerated: First, the adherent lung may be wounded if the puncture be made at a point too high, or the diaphragm, if at a point too low. This danger is to be obviated by determining the areas of dullness at all points of the affected side, and the level of the base of the sound lung as a guiding line. The point of election is the sixth or seventh interspace, in the line of the posterior axillary fold. To the objection that this is not the most dependent region of the cavity, I reply that as the pus escapes the diaphragm rises, and that a line some distance above the floor of the cavity before tapping, speedily corresponds to the level of its floor after the operation. At the point indicated, the muscular wall of the chest is not so thick as farther back, nor are the integuments so sensitive as farther forward. Furthermore, in the recumbent posture, this point is favorable to drainage by gravity.

Second, collapse may result from the sudden withdrawal of a large collection of fluid. This danger is to be averted by two expedients. Of these, the more important is the preliminary withdrawal of a portion of the pus by aspiration, a procedure which I practice in all cases for the following reasons, namely: (*a*) To determine the resistance of the intercostal structures at the position of choice for the radical operation. (*b*) To ascertain the precise character of the fluid. (*c*) To re-assure the patient by exhibiting to him the fluid thus withdrawn, and to inspire his confidence by the temporary relief aspiration affords. And finally, (*d*) For the purpose indicated, that is to obviate the risk of collapse by the previous withdrawal of a part of the exudation. When the circumstances permit it, the preliminary operation should be practiced two or three days prior to the radical operation.

The second expedient is the temporary arrest of the flow by mechanical means if collapse is threatened. It is needless to say that an opiate, preferably morphia hypodermically, and stimulants, are given prior to the operation, to anticipate this danger.

Of the remote dangers resulting from the operation, I shall allude to two only. These are septicemia, from infection through the freshly-abraded tissues, and sudden death in the course of subsequent treatment.

Of the danger of sudden death during the after treatment, I can only say that it is of sufficiently frequent occurrence to invest the care of these cases with an enormous responsibility. It occurs, in most cases, from

heart-clot; less frequently, as Bartels suggested, from sudden alteration in the position of the heart in such a way that the ascending vena-cava was bent upon itself, at its emergence through the foramen quadratum; and occasionally from causes that are, as yet, wholly beyond conjecture.

The operation does not call for general anesthesia. The common practice of applying ice to the skin to produce local anesthesia probably does not lessen the necessary pain, and is pain in itself.

The main steps of the operation, and the subsequent treatment, may be briefly outlined as follows:

The preliminary aspiration. The puncture, by means of short trocars (not exceeding in length two inches), the canula being retained only until the pus ceases to flow, when a soft rubber catheter (Nelaton or Jacques) is slipped into position and the metal canula withdrawn. Catheters are preferable to sections of drainage-tube, by reason of the ease with which they can be introduced into the sinus by means of a probe. It is occasionally necessary to change the catheter, or to remove it to clean it.

The washing of the cavity by means of a ball syringe and a system of soft rubber tubing, the connection being made by sections of tapering glass tubes, is to be repeated once or twice a day. The temperature of the water injected should be 102° – 5° F., and the amount of force used very slight. At the first sitting no more should be injected each time than one-fourth the volume of the pus withdrawn. This injection is to be repeated at each sitting until the water returns only slightly turbid or clear. After having used for this purpose many of the disinfectants in vogue, I have settled upon the mercuric bichloride as the most efficient and convenient. At first, I used one part to 15,000, then one to 8,000, and finally one to 5,000.

In the intervals of the dressings, the patient wears a large pad of oakum to absorb the discharge.

As the cavity contracts, and the discharge diminishes, the interval between the washings may be much prolonged; when the discharge becomes serous, and does not exceed two fluid drachms, the tube should be withdrawn and the sinus permitted to heal.

If a spontaneous opening has formed in the chest wall, the plan of treatment is not thereby modified. Such sinuses are badly located, oblique, often tortuous, and always ineligible for operative purposes. In such cases, proceed as though no spontaneous opening existed. After the operation, such openings speedily heal. Bronchial fistulæ are equally without influence in modifying the treatment.—*J. C. Wilson, M. D.—Philadelphia Reporter.*

NEW TREATMENT OF GONORRHEA.—Hot water retrojection is advocated by Dr. Curtis (*Medical Record*). By means of an apparatus which he has devised, one is enabled to pass several quarts of hot water through the urethral canal from the prostatic portion outward, increasing the temperature of the water all the time until 180° to 190° F. may be reached. He has passed as much as ten quarts of water in this manner. After the use of the water, a mild astringent is passed through the same catheter, and the instrument withdrawn. He gives the results of twenty cases treated in this way. In twelve cases of undoubted acute gonorrhea, the discharge was entirely checked in three days. In two cases he aborted the disease by one prolonged injection of ten quarts. In six cases the disease lasted from six to ten days, while a case of gleet, of nine months standing, yielded in seven days to dilatation and retrojection. He claims for this method: First. The course of the disease is shortened, making the average limit of the case nearer one week than three. Second. The discharge immediately changes in character, and is reduced to a very small quantity. Third. There is absence of chordee and pain in passing urine. Fourth. Stricture as a sequence is improbable. Fifth. The usual inconveniences of the disease are done away with. His apparatus consists of an ordinary wooden arm-chair, out of which a piece is cut in the front of the seat to admit a tall cuspidor; a pulley rigged to the ceiling, with which a tin pail with a lamp beneath is elevated; a rubber tube, provided with a stopcock and connection leading from the pail, and to which an ordinary No. 8 English catheter is fitted. Instead of this apparatus, an ordinary Davidson's syringe may be used. The only internal treatment is bicarbonate of soda.

BORAX IN THE TREATMENT OF IMPACTION OF CERUMEN.—Dr. Geo. F. Sowers (*Med. and Surg. Reporter*) gives the following formula for dissolving impacted cerumen, so that it can be removed with the syringe:

R—Sodii boratis, pulv, $\frac{3}{4}$ i.
 Glycerine }
 Aquæ } a. a., $\frac{3}{4}$ ii.

M.—Sig.—Warm, and drop into the ear. After it has liquefied the cerumen, use syringe and tepid water.

DR. GUIDO BELL, of Indianapolis, highly recommends (in *Amer. Practitioner*) Lactopeptine in the treatment of indolent ulcers. He sprinkles it on the surface once or twice a day.

REVIEWS AND BOOK NOTICES.

Prices are always inserted when furnished by the publisher, or when obtainable from the bookseller.

Therapeutical Hand-book of the United States Pharmacopeia; being a condensed statement of the physiological and toxic action, medical value, methods of administration and doses of the drugs and preparations in the latest edition of the United States Pharmacopeia, with some remarks on unofficial preparations, by Robert T. Edes, M. D., (Harvard). Professor of Materia Medica in Harvard University; President of the American Neurological Association, etc. William Wood & Co., New York, 1883. Cloth, 8vo., Pp. 397.

This work is intended to be a condensed list of the remedies contained in the latest edition of the Pharmacopeia, with the addition of the therapeutical application of each article. The work has been well executed, and its conciseness and completeness deserve praise. What the Pharmacopeia is for dispensing pharmacists, this commentary is designed to be to practicing physicians. The author, in the therapeutical application of medicines, suggests principles of treatment, rather than specific applications of remedies. Practitioners are too apt to treat diseases by their name, and we are glad to see such practice discouraged.

The typographical appearance of the book is unusually fine.

The Systemic Treatment of Nerve Prostration and Hysteria. By W. S. Playfair, M. D., F. R. C. P. etc. Philadelphia: Henry C. Lea's Son & Co. 1883. Cloth. 12mo. Pp. 111.

The treatment here recommended, and illustrated by cases, is identical with that suggested by Dr. S. Weir Mitchell, of Philadelphia, several years ago, to whom, indeed, full credit is given by the author. He regards Dr. Mitchell's treatment as new only in the sense that his recommendations were by him for the first time combined so as to form a complete scheme of treatment. The book is valuable as combining the experience of the two men.

Home Health: or, The Popular Science of Hygiene, is a journal devoted to the advancement of practical knowledge of the laws of life, sanitation and all subjects pertaining to home health. It is edited by Romaine J. Curtiss, M. D., and Thomas M. McIlvaine, M. D., and is published at Peoria, Ills. Pp. 48. \$2. Specimen copy free.

This is an attempt to popularize hygiene and medical science, and we hope for it a high degree of success.

Dispensatory of the United States of America. By Dr. George B. Wood and Dr. Franklin Bache; fifteenth edition. Rearranged, thoroughly revised and largely rewritten. With illustrations; by H. C. Wood, M. D., Professor of Materia Medica and Therapeutics, University of Pennsylvania, etc.; Joseph P. Remington, Ph. G., Professor of Theory and Practice of Pharmacy in Philadelphia College of Pharmacy, etc.; and Samuel P. Sadtler, Ph.D., F.C.S., Professor of Chemistry in Philadelphia College of Pharmacy, etc. Philadelphia: J. B. Lippincott & Co. 1883. Leather. 8vo. Pp. 1928. Price, \$8.

It would probably be a sufficient notice of this valuable work to state that the edition just issued contains corrections of the errors to be found in the former editions, and numerous additions, both as to the subjects and as to the articles of the Materia Medica not mentioned in those editions. We desire, however, to call attention to some of the important features of the publication now before us. In the first place we have here a corps of three competent editors—one for Materia Medica, pharmacy, etc.; one for the chemical department, and one for the physiological and therapeutical action of drugs. Another improvement is that we have the chemical analysis of most of the important mineral springs of the United States, as well as many of the most renowned springs of Europe. Weights are given in accordance with both the old and the new methods.

The correct pronunciation of the names of the drugs is also given in parenthesis under each title. This will be advantageous to both physicians and pharmacists. We imagine there will be some surprise when such a word as *colchicum* is looked at, the correct pronunciation of which is very different from that in ordinary use.

Although much additional matter is furnished in this edition, the price has been reduced to \$8, owing undoubtedly to competition with the *National*.

Rheumatism, Gout, and Some Allied Disorders. By Morris Longstreth, M. D., one of the Attending Physicians to the Pennsylvania Hospital, etc., New York: William Wood & Co. 1882. Pp. 280

This is the October (1882) No. of "Wood's Library of Standard Medical Authors."

The author thinks the salicylic treatment of rheumatism is undoubtedly superior to all others. With which opinion, however, some practitioners do not agree, who find cases that only yield to the "six weeks and flannel" treatment of the past.

In the treatment of gout, nothing new appears; alkalies and colchicum are still the chief remedies.

Diseases of the Liver, With and without Jaundice, with the Special Application of Physiological Chemistry to their Diagnosis and Treatment. By George Harley, M.D.; F.R.S., F.R.C.S., Physician to University College Hospital, etc. Illustrated by colored plates and wood engravings. Philadelphia. P. Blakiston, Son & Co. 1883. 8vo. Pp. 751.

In some features, this book differs from most treatises on the same subject. The author devotes an unusually large space to the chemistry, physics, and physiology of the liver, as a knowledge of these elementary subjects is of prime importance to a correct understanding and appreciation of what is to follow. Diagnosis and treatment are about as usual. That vague condition called, for the sake of a name, "biliousness," is quite fully described, and this chapter contains many valuable suggestions. Abscess, Cancer, Hydatids, etc., are treated of in order. Affections of the gall-bladder are grouped by themselves.

Dr. Harley has been so long identified with the subject of this work, that the book will naturally and deservedly attract attention.

Alcoholic Inebriety.—From a Medical Standpoint, with Cases from Clinical Records. By Joseph Parrish, M. D. P. Blakiston, Son & Co., 1883. 8vo. Pp 185. Cloth. \$1.25.

The question of the relationship of insanity and inebriety is here discussed and developed. Interesting cases are introduced to illustrate the leading ideas of the work. The author believes that inebriety is a disease, which may be traumatic, hereditary, or acquired by bad habits. The relationship between inebriety and insanity is well shown. The treatment of this disease is based upon its distinction from vice on the one hand, and from other forms of insanity on the other. The author remarks at some length on the different alcohols and their effects, and upon the psychology of inebriety. The monograph will lead the reader to reflect seriously upon the effects of alcohol, and to look with sympathy upon its victims. It should be widely read.

Headaches: Their Nature, Causes and Treatment. By Wm. Henry Day, M.D., M.R.C.P., Lond., etc. Fourth edition. With Illustrations. Philadelphia: P. Blakiston, Son & Co. 1883. 8vo. Pp. 149. Price, \$1.25; paper, 75 cents.

We have have already noticed the former edition of this book, which has been recommended by the journals, and by leading specialists both of this country and of Europe. It will be found to be a very useful book for consultation in reference to peculiar cases of headache, as it discusses thoroughly all the features of that frequently perplexing malady.

A Dictionary of Medicine. Including General Pathology, General Therapeutics, Hygiene and the Diseases Peculiar to Women and Children. By various writers. Edited by Richard Quain, M.D., F.R.S., Fellow and late Senior Censor of the Royal College of Physicians, etc., etc. New York: D. Appleton & Co. 1883. 1 vol., 8vo. Pp. 1816. \$8. Cincinnati: O. J. Rowe, 200 Main St.

This grand work is rather an encyclopedia than a dictionary. It is a complete storehouse of information, containing, in accessible and concise form, the results of the most recent investigation upon all important subjects relating to general pathology, general therapeutics, hygiene, and the diseases of women and children. Grainger Stewart gives us the results of recent investigations on Bright's disease; C. Theodore Williams, the same on phthisis; J. Henry Bennett, climate upon disease; Pavy, on diet; Simon, on contagion; Tuke, on insanity; while upon the diseases of the heart and kidney and liver, as well as upon general diseases, are here the latest ideas of those who are, by special qualification, best fitted to instruct. To bring this array of talent together, and to combine the separate parts into a symmetrical whole, required both great scholarship and tact, and also indomitable energy and untiring industry. Among the most noted contributors are, Jenner, Playfair, Bristowe, Paget, Thompson, Wells, Murchison, Bastian, Roberts, Grainger Stewart, and Hutchinson, of England; Baumler, of Frieberg; Binz, of Bonn; Howard and Jones, of the United States; and Brown-Sequard, of France.

The book is not a dictionary, like that of Dunglison, for the definition of terms, but rather an encyclopedia; a sort of Ziemssen condensed and expurgated; it is to medicine what the *Encyclopedia Britannica* is to science, art and literature.

It is in a single large volume, of nearly two thousand pages, so as to be most convenient for reference; well bound in half-morocco, so as to be both ornamental and durable; and printed with all the care that characterizes the work of the Appletons.

The work is of such real value to both practitioner and student, that it would be cheap at double the price, which is so low that none can afford to be without it.

THE June number of the *North American Review* opens with an article by Joseph Nimmo, Chief of the Treasury Bureau of Statistics, on "American Manufacturing Interests," in which is given a singularly full and instructive historical sketch of the rise and progress of manufactures in the United States, together with a very effective presentation of their present condition, and of the urgency of tariff legislation in promoting diversified

industries, and encouraging the inventive genius of the people. Should this author's advocacy of protective legislation prove distasteful, the reader finds the needed corrective in an article by the Hon. Wm. M. Springer, on "Incidental Taxation," which is an argument for Free Trade. D. C. Gilman, President of Johns Hopkins University, writes of the "Present Aspects of College Training," as affected by the increase of wealth and luxury, the development of natural science, and the influence of a larger religious liberty. Edward Self presents some weighty considerations on the "Abuse of Citizenship," as exhibited in the machinations of the dynamitists against a friendly power, in disregard of the obligations of American neutrality. Prof. Isaac L. Rice criticizes some of "Herbert Spencer's Facts and Inferences" in social and political science, and Christine Nilsson contributes a few words about "Public Singing." Finally there is a symposium on "The Moral Influence of the Drama," the participants being on the one side the Rev. Dr. J. M. Buckley, well known as an opponent of the stage, and on the other John Gilbert, the actor; and A. M. Palmer, theatrical manager; and William Winter, dramatic critic.

Indoors and Outdoors.—Devoted to Town and Country Improvement, Healthy Homes and Beautiful Surroundings. Vol. I, No. I. New York, May 1. Monthly; 50 cents per year; edited by Chas. F. Wingate and John Y. Culyer. 119 Pearl Street.

This Journal is the organ of the National Association for Sanitary and Rural Improvement. Its initial number is an excellent one, and its field is so broad that there should be no difficulty in its supply of material for future issues. There is a growing demand for this kind of literature, which cannot be too much encouraged. The *cure* of disease has a dismal record of almost uniform failure; the *prevention* of disease has a brilliant future before it.

The American Psychological Journal.—This is a new quarterly journal issued by the National Association for the Protection of the Insane and the Prevention of Insanity. It is edited by Dr. Joseph Parrish, with A. A. Chevaillier, and Drs. W. W. Godding, C. L. Dana, H. H. Banister, and J. C. Shaw, associates. The publishers are P. Blakiston, Son & Co., Philadelphia.

The first number contains original articles from such well-known men as J. Milner Fothergill, Norman Kerr, William Julius Mickle, W. W. Godding, C. K. Mills, Walter Channing, Crothers, H. Marion Sims, and others. The publishers have done their work excellently.

A Hand-book of the Diagnosis and Treatment of Disease of the Throat, Nose and Naso-Pharynx. By Carl Seiler, M.D., Lecturer on Laryngoscopy at the University of Pennsylvania, etc. Second edition; thoroughly revised and greatly enlarged. With seventy-seven illustrations. Philadelphia: Henry C. Lea's Son & Co. 1883. 12mo. Pp. 295.

This work is a concise hand-book upon the essentials of diagnosis and treatment in diseases of the throat and nose. Laryngoscopy, the anatomy of the throat and nose, and the pathology of their mucous membrane, are discussed with commendable conciseness. Chronic nasal catarrh and laryngitis are considered with much detail as to local treatment. The author gives evidence of originality and skill in the invention and use of apparatus.

The work presents many excellent features, and while not so full and large as some, is full enough for most practical purposes.

A Compend of Human Physiology. For the use of Medical Students. By A. P. Brubaker, M.D., Demonstrator of Physiology in Jefferson Medical College, etc. Philadelphia: P. Blakiston, Son & Co. 1883. Cloth, \$1.00.

This is a very practical little summary of physiology, prepared by one unusually well qualified for the task. It will aid students very materially in fixing in their minds these foundation facts of medicine—what Prof. Meigs used to call the “Institutes of Medicine.” The book is not designed to take the place of the systematic treatises on the subject, but merely to assist the memory.

An Index to the Practice of Medicine.—By Wesley M. Carpenter, M. D., Assistant Pathologist to Bellevue Hospital, etc., etc. Flexible covers, with Tuck. Interleaved. Pp. 304. Wm. Wood & Co., New York. Price, \$2.50 and \$3.50.

This beautiful manual of the practice of medicine is written from a clinical standpoint, and is designed as an aid to the study and practice of medicine, and gives in condensed style the essential facts gathered from a wide field of study and observation. The printing, paper, and binding are each, in its way, superb. It is interleaved for notes, and is admirably adapted to the wants of the young physician who desires to quickly review his knowledge in a moment of necessity. Even the experienced practitioner will find it valuable as a condensed account of the practice that is indorsed by the authorities of the present day.

Students' Guide to Diseases of the Eye.—By Edward Nettleship, F. R. C. S., Ophthalmic Surgeon to St. Thomas's Hospital, etc., with a chapter on examination for color perception, by Wm. Thompson, M. D., Prof. Ophthalmology Jefferson Medical College. Second American, from the Second and Revised English Edition. 8 vo. Pp. 416. Philadelphia. H. C. Lea's Son & Co. 1883.

This edition is much enlarged and improved. Prof. Thompson, who adds a most important chapter, is well known as a distinguished practitioner in this department. The work has the advantage of brevity and condensation, extensive quotations from the older authors being omitted. The style being simple and clear, the book is handsomely and plainly illustrated, and neatly printed.

A Manual of Auscultation and Percussion.—Embracing the Physical Diagnosis of Diseases of the Lungs and Heart, and of Thoracic Aneurism. By Austin Flint, M. D., Professor of the Principles and Practice of Medicine and Clinical Medicine in the Bellevue Hospital Medical College, etc., etc. Third Edition, Revised. Henry C. Lea's Son & Co., Philadelphia. 1883. Royal, 12mo. Pp. 242.

His admirers will welcome the third edition of this work, which is so well and favorably known as to require on our part but mere mention. The author has introduced his methods of reproducing pulmonary signs in lungs removed from the body, as well as artificial illustrations. As a hand-book upon a most important subject it has no rival.

Early Aid in Injuries and Accidents. By Dr. Friedrich Esmarch, Prof. Surgery Univ. of Kiel, etc. Translated from the German by H. R. H. Princess Christian. Philadelphia, Henry C. Lea's Son & Co. 1883. 12 mo. Pp. 117.

The nature of this excellent little volume is fully expressed in its title. It is a novelty in its way, and will be found useful to every practising physician. If it were generally introduced into Grammar and High Schools, it would be the means of doing much good. The language is very plain, so that any person can comprehend it.

COLUMBUS MEDICAL JOURNAL.

EDITORIAL.

RETROSPECT—*Pharmaceutical.*

The Wm. S. Merrell Chemical Co.'s *Resinoids* and *Alkaloids* are not excelled for *purity* and *reliability*. Sulph. Hydrastia (Berberina) in Crystals; as well as the Muriate, Phosphate, and Principles Combined; Podophyllin, Leptandrin, Nitrate Sanguinarina, and many other leading articles in these lines *originated* with them, and were brought to *present perfection* through their investigations.

Pure Salicylic Acid from Oil Wintergreen is one of the *fine specialties* of the Wm. S. Merrell Chemical Co. It is equal in purity to the finest German imported, which is sold in powder and liable to *adulteration*. The Crystalline form of the Wm. S. M. Chem. Co. preparation is a protection against this growing evil.

Nitrate Sanguinarina—Introduced by the Wm. S. M. Chem. Co.—For extended notes on this preparation send for circular. In *Croup*, Scarlatina, Diphtheritis, Pseudo-Membranous Croup, Nitrate Sanguinarina has proved to be almost a specific; not only relieving the inflammation of the fauces, but also dissolving the adventitious formation.

The *Green Drug Fluid Extracts* of the Wm. S. Merrell Chemical Co. challenge comparison as to medicinal strength, physical appearance, and positive therapeutic efficacy. As a *secondary* consideration we may add that an average saving of nearly *one-third* is gained by their use, especially by those physicians who have been paying exorbitant prices for the use of the copy-righted label "*Specific Medicines*."

Hydrastia—*Pure White Alkaloid, in crystals*.—This Alkaloid exists in the root in very small proportions. It is coming into use, however, triturated with Sugar of Milk; and also in combination with Subnitrate Bismuth in the preparation introduced by the Wm. S. Merrell Chemical Co. as "*Solution Bismuth and Hydrastia*."

"Specific Medication" is the practical application of a correct theory;—the use of the *so-called* "Specific Medicines," under an impression that they are essential to the *success* of the principle, is a fallacy, which is thoroughly exposed in our paper—"The Fluid Extracts of the Wm. S. Merrell Chemical Co. vs. the *so-called Specific Medicines*." The argument therein has never been answered. Send for a copy.

The great success attending its sale is convincing proof that "*Fluid Hydrastis*" *perfectly fulfils* the indications for its use suggested in the circular issued by its originators, the Wm. S. Merrell Chemical Co.

MESSRS. BRAUN & BRUCK, Wholesale Druggists, *Columbus, O.* are agents for the Wm. S. Merrell Chemical Co.'s Preparations. Physicians may obtain from them any article made by this "Co." If not in stock, it will be furnished at short notice.

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We have *no authorized Collectors*, except such as carry properly made out bills, *counter signed by the Publishers*.

HANN & ADAIR, Publishers, Columbus.

PHYSICIANS AND THE BICYCLE.

It may be regarded as settled, by the universal agreement of all wheelmen, that a man can, on fair roads, make forty to fifty miles a day on a bicycle, and be no more fatigued at the close than if he had ridden an easy saddle horse the same distance. Under special circumstances, a hundred miles a day is no very unusual feat, while nearly double this distance has been accomplished. The ordinary speed may be placed at eight miles an hour, though ten is easily made, and even twelve.

Light packages, such as instrument case, medicine case, umbrella, rubber coat, etc., can be carried, attached to the handle bar.

For night riding, the lamp with which they are provided renders their use entirely free from danger.

The cost of a machine of average size and medium finish is about \$125. Five dollars a year will pay for oil and all probable repairs. If any part becomes worn out or broken, it can be quickly and easily replaced by a new one, as all parts are machine-made and interchangeable. The entire machine being either plated or enameled, is protected against rust and is easily cleaned.

Such is the bicycle and its capabilities, and we now propose to consider,

as briefly and practically as possible, two distinct subjects: 1, The use of the bicycle by physicians; 2, The use of it by patients.

1. For professional use the bicycle has its advantages and its disadvantages. The question was thoroughly discussed two years ago, in the *London Lancet* and *British Medical Journal*, and the testimony of the scores of physicians then using it (or the tricycle) was overwhelmingly in its favor. Since that time its use by medical men has largely increased in Great Britain and on the Continent, and it is beginning to come into use in this country.

It can be used whenever and wherever driving is pleasant. It cannot, of course, be used where hills are very numerous and steep, though reasonable inclines offer no obstacle, nor can it be used when roads are very muddy or sandy. But in most parts of the United States, and especially in the level or rolling regions of the Great West, the bicycle can be profitably used during about eight months of the year. It requires no stable nor groom, eats nothing, is always ready, is never sick or lame, shies at nothing, and will not kick nor run away.

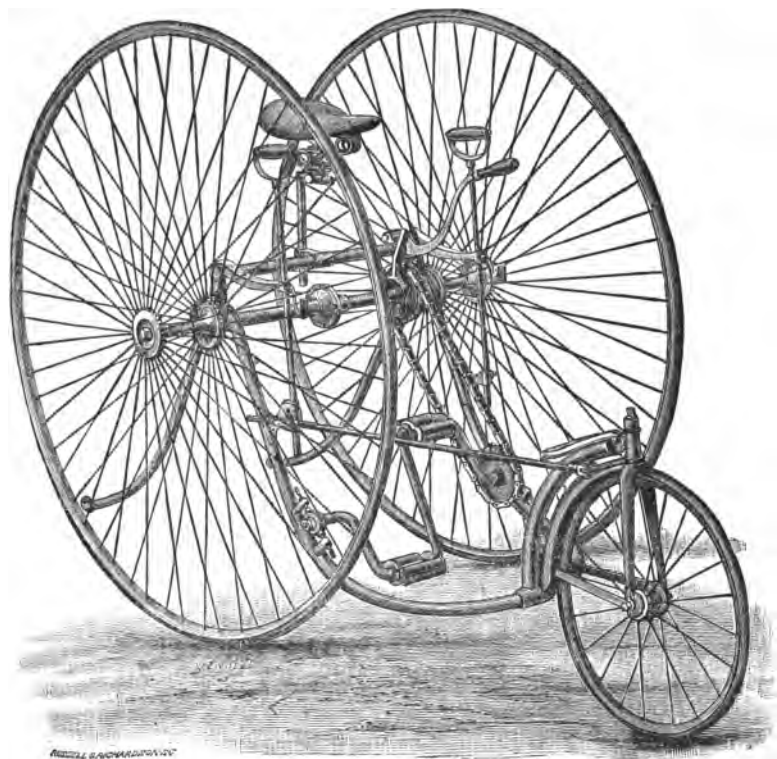
On the other hand, and in contrast, a fair horse (we say nothing of buggy or harness or repairs in this comparison) costs in this city \$175; board for a year, \$216; shoeing, \$18; while the risk of disease, accident and death is by no means inconsiderable. For eight months of the year, therefore, the expense account is vastly in favor of the bicycle. During the remainder of the year, a horse must be owned or hired.

As to safety, the learner on the bicycle, as on the horse, is apt to have a few tumbles, though many escape even these, but a serious accident is almost unheard-of, while practice soon renders falls almost impossible.

But some may say the physician who uses a bicycle loses dignity and reputation. If that were true, it would certainly prove a serious objection; but it is not true, at least here in Columbus, nor in England, nor on the Continent; if it is true anywhere, we have yet to hear of it. The objection is purely an imaginary one. It is infinitely easier to ride a bicycle well than a horse; and even a fair rider is never undignified. The Massachusetts Bicycle Club is largely composed of business and professional men. The average age is over thirty years, and of twelve members who recently took a breakfast "run" to Waltham, all but one wore a beard, and the average age was thirty-seven—the youngest being thirty and the eldest fifty years of age.

What has been said of the bicycle applies almost equally well to the

tricycle.* The latter is a trifle heavier, but requires absolutely no skill to



ride with safety and ease, while its speed nearly equals that of the bicycle. Prof. Nulle, of Hillsboro, O., after a month's use of a tricycle, writes that he "made a long and hard trip of thirty-two miles over an extremely hilly and rough road, in four hours and thirty minutes; an average of about seven miles per hour."

For the use of middle-aged and elderly physicians, who are beginning to distrust their vigor and activity, the tricycle is certainly most admirably adapted, and it is undoubtedly superior to the bicycle for city practice, where one is obliged to stop frequently, and where it is occasionally desirable to use the sidewalk. It is, however, inferior to the bicycle, for coun-

*As the appearance of the former is familiar to all, while the latter is seldom seen, we have through the courtesy of the Pope Manufacturing Co., of Boston, introduced a cut of the tricycle. The large wheels are fifty-inch, the small one, eighteen-inch. Seat, handles, etc., are adjustable to any size of rider. Finished in nickel and enamel. As the two machines are, in their results, essentially alike, we shall generally, in this article, use the name *bicycle* as representing both.

try practice, in two respects : the latter is lighter and runs easier, which tells in a long ride ; and it makes but a single track (while the tricycle makes three), which enables it to run nicely, when the center of the roadway is rough, in the smooth track made by wagon wheels.

For the young physician just starting in practice, or for the established physician, who desires to save the expense of keeping an extra horse, or to send his horse out to grass for a few weeks or months—the bicycle offers a solution of the problem ; while those provoking calls that are forever coming in just after one's horse has been sent to the stable ; night calls ; hurried calls, when to wait for the horse to be hitched up may mean a fatal issue ; tedious labor cases—all these call into use, and very pleasant and profitable use, the ever-ready wheel.

2. For the use of patients who need exercise, there is probably nothing superior to the bicycle—nothing equal to it save the horse.

True exercise, in the ordinary use of the term, involves recreation, and consists of several elements. *It must give pleasure* ; the calisthenics, or "constitutional walk," of the Young Ladies' Seminary, performed under the eye of the teacher, and in a mechanical, perfunctory way, is almost worthless. "The stimulus of a pleasant pastime enables a man to beguile himself into about ten times as much exercise as he could stand in the Turner-hall. The visitors of a hygienic gymnasium take their turn at the horizontal bar, as they would swallow drugs : they know that it is a lesser evil ; that the road to Styx is the alternative ; they intend to come every day, but the intolerable tedium of the exercise soon shakes that resolution, and nine out of ten hygienic gymnasts will soon find or make a pretext for discontinuing their visits." (Oswald.) *It must not require mental exertion*, at least not similar to that of the working hours. *It must not be excessive*, nor too violent : forced marching, hard rowing, heavy lifting, all tend to hypertrophy of the heart, and noted athletes are very liable to heart and lung diseases. *It must not be taken too hastily* : "health lifts," and similar devices for taking a large amount of exercise in a limited time, are an utter abomination ; they strain the muscles, but do not exercise them. Time must be sacrificed in order to get the full effects of exercise. *It should be in the open air* : the wounded in carefully constructed hospitals, have frequently, after a great battle, had a higher mortality than their comrades, who were crowded out into tents and open sheds.

Exercise acts beneficially in two ways, and only two (Prof. H. C. Wood): 1. By increased action of muscles, an increased amount of effete matter is thrown into the blood and oxidized, while fresh matter takes the



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